3

State Assisted Living Policy: 1996

Prepared by

Robert L. Mollica
Kimberly Irvin Snow

Novem ber
1996

NATIONAL ACADEMY
for STATE HEALTH POLICY

50 Monument Square, Suite 502
Portland, Maine 04 10 1
Phone [207] 874-6524

This project is supported by a contract from the US Department of Health and Human Services, the Office of the Assistant Secretary for Planning and Evaluation, grant number HHS-100-94-0024. Additional funding for the project has been provided by the Administration on Aging, the National Institute on Aging and the Alzheimer's Association.

Preface

NATIONAL STUDY OF ASSISTED LIVING FOR THE FRAIL ELDERLY
Sponsored by the U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation (ASPE)

Project Overview

Assisted living facilities are a rapidly expanding source of supportive housing with services. In the view of many, such facilities represent a promising new model of long-term care, one that blurs the sharp and invidious distinction between nursing homes and community-based long-term care and reduces the chasm between receiving long-term care in one's own home and in an institution. In this model, consumer control and choice are central to the philosophy of "assisted living." Indeed, the ability of consumers to control both key features of the environment and to direct services, under a "negotiated" or "managed risk" model, and to receive care and supervision in a "home-like" setting are considered hallmarks of the philosophy of assisted living. Further, assisted living, at least conceptually, is distinguished by a flexible service arrangement, in which there is no set "package" of services but facilities provide services to meet scheduled and unscheduled needs of residents, which would allow residents to "age-in-place."

Despite this growing interest in and expansion of places calling themselves assisted living, relatively little is known about their actual role and performance and the degree to which they represent a viable option for frail and disabled elders. Indeed, there is not even agreement or information on the number of such facilities currently in operation. As a result, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services is undertaking a national study of the role of assisted living. ASPE entered into a contract for a comprehensive study to be conducted by Research Triangle Institute (RTI) and its collaborators, Lewin, Inc., the University of Minnesota Long-Term Care Resources Center, and the National Academy for State Health Policy.

Purpose of the Study

The focus of the *National Study of Assisted Living for the Frail Elderly* is to determine where "assisted living" fits in the continuum of long term care and to examine its potential for meeting the needs of a growing population of elderly persons with disabilities. Within this broad objective, the study will address several specific issues, including:

1. To identify trends in demand for and supply of assisted living facilities;

2. To identify barriers to development of assisted living and factors that contribute to those trends in demand and supply;

In addition, the study has further descriptive and "evaluative" goals:

3. To determine the extent to which the current supply matches the central philosophical and environmental tenets embodied in the concept of "assisted living" and to describe the key characteristics of the universe of assisted living facilities; and

4. To examine the effect of key features that embody the philosophical tenets on selected outcomes, including resident satisfaction, autonomy, affordability, and potential to provide nursing home-level of care.

Overview of the Study Design

- We will select and interview a purposive sample of lenders, developers, and multi-facility owners.

- We are conducting annual surveys of all State licensing agencies involved in assisted living, as well as of Medicaid agencies that provide funding for assisted living. In addition, we will survey key federal policy-makers.

- The study will draw a national probability sample of facilities; this will allow us to generalize our findings and make valid estimates about the status of assisted living facilities across the nation.

- Using this sample, the study will describe the key characteristics of places holding themselves out to be "assisted living" facilities, based on a telephone survey of about 2,500 facilities.

- In addition, we will select a sample of 690 facilities that will be visited, with in-person interviews with operators, staff and residents. This data collection will allow us to examine the effect of differences in key facility characteristics (e.g., service mix and environment) on such issues of interest as resident satisfaction, resident autonomy, affordability for low and moderate-income elderly, and the degree to which assisted living does or can "substitute" for nursing home care.

- Finally, we plan to interview a sample of families of residents with cognitive impairment who are unable to respond to the "satisfaction" questions for themselves and a subsample of the resident sample who six months after the initial interview have been discharged or otherwise exited the facility.

The project team is led by Catherine Hawes at RTI and includes Barbara Manard, Lewin VHI, Inc.; Rosalie Kane, University of Minnesota; and Robert Mollica, National Academy for State Health Policy. The ASPE project officer is Robert Clark.

This project is supported by a contact from the US Department of Health and Human Services, the Office of the Assistant Secretary for Planning and Evaluation, contract number HHS-100-94-0024. Additional funding for the project has been provided by the Administration on Aging, the National Institute on Aging and the Alzheimer's Association.

Contents

Acknowledgement

The authors with to thank the many people in state agencies throughout the country who provided copies of statutes, regulations and reports that enabled us to compile this report. We also appreciate their willingness to discuss their programs and review drafts of the material in this report. Such a project would not possible without the support of dedicated professionals in state agencies who are willing to share their time and knowledge in this endeavor. We hope the information is helpful to states as policies on assisted living continue to emerge and develop over time.

Executive Summary

This study reviewed the assisted living and board and care policies in each of the 50 states. Fifteen states have existing licensure regulations for assisted living facilities. Regulations are being developed by an additional nine states. Twenty two states reimburse, or plan to reimburse, assisted living as a Medicaid service including states that do not have a licensure category for assisted living. Six states provide Medicaid payments for services in board and care settings and thirteen states had created a task force or a process within a state agency to make recommendations for the development of assisted living rules.

While a common or standard definition of assisted living is unlikely, state approaches share some common components. This new model for providing long term care is developing as a residential, rather than institutional, model. While many observers equate institutional with medical, the distinction between medical and social lies less with the services delivered than the setting itself. State rules generally require residential settings in which personal care and health related services are provided. Even though the setting is residential, health or medical services are provided, either by facility staff or through contracts with community agencies.

Policies in fourteen states include a statement of philosophy that describes assisted living as a model which emphasizes consumer or resident independence, autonomy, dignity, privacy and decision-making.

During interviews, state policy makers talked about the limits of regulations to ensure safety and quality of care. Instead, assisted living approaches in many states reflect attempts to combine minimum standards with market forces to produce quality. In many states, new rules reflect a combination of market trends and the lobbying influence of organizations with a stake in the shape and direction of the rules. It is also clear that regulations set the parameters for assisted living while owners/operators define the practice. Despite regulations that may allow a higher level of care, facilities themselves may set their admission/retention policy to care for less impaired residents than the rules allow and provide a less intensive service package than allowed. Though strong market demand from moderate and upper income residents for residential settings supports this practice, changes are likely over time as the number of facilities expands, residents age in place and providers adjust to maintain high occupancy rates.

The three major issues addressed by state policies are the requirement for the living unit, tenant admission/retention criteria and the level of services. Existing or proposed policy in fourteen states would require apartment settings while twelve states

allow both facilities with apartments and facilities with shared rooms to be licensed or reimbursed as assisted living. Shared rooms meet the minimum standards in four states.

New Jersey and Oregon have the broadest admission/retention criteria. New Jersey's rules require 20% of the residents in each facility meet the nursing home level of care criteria within three years of licensure. Two primary approaches have been used to set criteria. States typically either require that residents have stable medical conditions and do not need 24 hour skilled nursing care or the policy lists a series of conditions that residents may or may not have to be served. The services that facilities provide parallel the admission/retention criteria.

In creating a new model, either through licensure or Medicaid, states are supporting an alternative to nursing homes for elderly recipients who need personal care and routine, scheduled nursing services. States seek to provide these alternatives both in response to beneficiary demand for non-institutional care and because of the high cost of nursing home care. About 35% of Medicaid spending pays for long term care. In 1993, recipients who were disabled made up 5.5% of the caseload and 37% of spending. Elderly recipients accounted for 11.5% of total recipients and just under 32% of all spending. Expenditures per recipient averaged nearly $9300 of which $2365 was spent on acute services and $6907 paid for long term care. Just over $5800 of the long term care spending paid for care in a nursing home. While disabled recipients account for higher total spending, per capita spending was less than for aged recipients at $7900 with $4500 covering acute care and only $924 per recipient paid to nursing homes. These patterns highlight the importance of addressing long term care spending for elderly recipients and acute care spending for disabled recipients for states that are interested in affecting Medicaid spending.

Finally, states are refining their Medicaid reimbursement methodologies to pay for assisted living. Washington state has developed a methodology that reimburses for three levels of care with regional variations. Rate components were developed for nursing services, operations (including personal care and other service costs) and capital costs. Newly constructed facilities also receive a "capital add on." New Jersey and Texas have created rates that vary by type of setting. Other states have set flat rates but plan to refine their methodology and develop a tiered or case mix adjusted rate as they gain experience with the program. One state will reimburse assisted living facilities on a fee for service basis as providers of Medicaid home and community based services.

Table 1. Summary of State Assisted Living Activity					
State	Existing regulations	Statute passed, drafting regulations[1]	Medicaid funding	Studying assisted living	Board & care
AL	✓			✓	
AS	✓		✓		
AZ			✓		
AR					✓
CA				✓	✓
CO			✓[2]		✓
CT	✓				
DE				✓	
FL	✓		✓		
GA			✓[2]		✓
HI		✓	✓[4]		
ID				✓	✓
IL			✓[3]	✓	
IN				✓	
IA		✓	✓[4]		
KN		✓	✓[4]		
KY		✓			
LA		✓			
ME	✓	✓	✓		
MD	✓	✓			
MA	✓		✓		
MI					✓
MN			✓		
MS					✓
MO			✓[2]		✓
NE				✓	
MT			✓[2]		✓
NV			✓[2]		✓

Table 1. Summary of State Assisted Living Activity					
State	Existing regulations	Statute passed, drafting regulations(1)	Medicaid funding	Studying assisted living	Board & care
NH					✓
NJ	✓		✓		
NM			✓		
NY			✓	✓	
NC	✓		✓		
ND			✓		
OH			✓[5]		
OK				✓	
OR	✓		✓		
PA				✓	✓
RI	✓				
SC				✓	✓
SD	✓		✓		
TN		✓			✓
TX			✓	✓	
UT	✓				
VA	✓		✓		
VT			✓[2]	✓	✓
WA			✓		
WV					✓
WI		✓	✓[4]		
WY	✓				

1. Or drafting regulations, legislation is not required.
2. Medicaid covers services in board and care settings through a waiver or as a state plan service.
3. Pilot projects authorized.
4. Decision is pending or a proposal will be submitted to HCFA.
5. A decision to submit a Medicaid waiver for assisted living has been postponed pending a study concerning the restructuring of Medicaid in Ohio.

Assisted Living At A Glance: Status of State Activities		
State	Status	Model"'
Alabama	Multiple categories are licensed based on size. The Department of Health held 2 meetings on assisted living to obtain suggestions for revisions. The State Health Coordinating Council is reviewing assisted living.	Institutional model.
Alaska	Statute passed in 1994. Regulations were effective in 1995. Services are reimbursed through a Medicaid HCBS waiver.	Multiple settings.
Arizona	Reimbursed as a Medicaid service through the ALTCS managed care program (1115 waiver). In 1996, legislation expanded the pilot program statewide.	New housing and services model.
Arkansas	Licenses residential care facilities. No assisted living activity.	Board and care.
California	A work group was formed in 1996 and the state's budget bill directed the Department of Health to submit a repot-t in January 1997. Currently licenses residential care facilities for the elderly.	Board and care.
Colorado	Licenses personal care boarding homes and Medicaid reimbursement is available through an HCBS waiver.	Board and care.
Connecticut	Regulations were effective in December 1994. Licensure **process implemented.** Four facilities have been licensed.	Service in apartment settings.
Delaware	Task force is developing regulations which are expected to be issued in 1997. Legislation seeking Medicaid funding will be filed as part of the Division of Services for Aging and Adults with Physical Disabilities' budget.	Multiple settings.
Florida	Regulations issued in 1992. Legislative amendments were passed and new regulations issued in 1996. An HCBS waiver has been approved to serve 225 Medicaid recipients.	Multiple settings.
Georgia	Licenses personal care homes. Medicaid reimbursement is available through an HCBS waiver. No assisted living activity.	Board and care.
Hawaii	Legislation creating assisted living was passed 1995. Draft regulations were issued in November 1996 comment.	New housing and services model.
Idaho	A concept paper was developed by the Residential Care Council in 1995. Legislation passed revising residential care facility rules. Further action on assisted living is being reviewed by the state agencies.	Board and care.

Assisted Living At A Glance: Status of State Activities		
State	**Status**	**Model[1]**
Illinois	The Illinois affiliate of the American Association of Homes and Services of the Aging created a coalition to support assisted living. A bill was drafted and is expected to be filed in the 1997 session. The legislature approved a supportive living facilities demonstration program that will serve 7500 people over five years.	Board and care.
Indiana	The Aging department is heading task force which may file legislation for consideration in 1997.	Board and care.
Iowa	SF 454 was signed by the governor in May 1996. Draft rules will be prepared in 1996. Implementation is planned for 1997.	New housing and services model.
Kansas	Law was passed in 1995 defining assisted living. Regulations will be finalized in the fall of 1996.	New housing and services model.
Kentucky	Legislation was passed in 1996.	New housing and services model.
Louisiana	Draft regulations have been developed.	Board and care.
Maine	Legislation revising the assisted living categories was passed in 1996 and regulations are being drafted. Services are reimbursed through Medicaid.	Multiple settings.
Maryland	Legislation was passed in 1996 based on a task force report.	Multiple settings.
Massachusetts	Legislation creating an assisted living certification process was signed in January 1995. Regulations have been issued. Certification process created for settings meeting specified criteria. Financing for services (Medicaid) and housing (SSI) are available for purpose built and conventional elderly housing projects. 60 projects and 3,700 units have been certified.	Multiple settings.
Michigan	In 1995, the Department on Aging led a work group that recommended no further regulatory changes. In 1996, a new group will be created to re-evaluate the issue.	Board and care.
Minnesota	Assisted living has been implemented as a Medicaid service.	Service in apartment settings.
Missouri	No activity to create assisted living has been identified. Medicaid reimbursement is available for residential care facilities.	Board and care.
Mississippi	No activity.	Board and care.
Montana	Assisted living is covered in personal care facilities as a Medicaid waiver service.	Board and care.

Assisted Living At A Glance: Status of State Activities		
State	Status	Model[1]
Nebraska	The Department of Health has formed a task force to revise existing residential care facility rules and perhaps create a new licensure category with a higher level of care. Managed Long Term Care Work Group will also consider where assisted living fits in the continuum of care.	Board and care.
New Hampshire	No activity to create assisted living has been identified.	Board and care.
Nevada	Licenses residential care facilities for groups. No assisted living activity. Limited Medicaid reimbursement is available.	Board and care.
New Jersey	Regulations creating a new licensure category were implemented. Ten facilities have been licensed, 140 have been approved and in the pipeline and 35 applications are pending. Regulations developing an assisted living model in elderly housing have been issued.	Multiple settings.
New Mexico	Assisted living has been added as a Medicaid waiver service.	Multiple settings.
New York	Contracts with 63 projects and 3500 units have been approved. An RFP for 700 units in New York City was issued and final selections have been made.	Multiple settings.
North Carolina	Chapter 535 (1995) defines assisted living residence as a category of adult care homes. Regulations revising the adult care home model have been issued and registration requirements for assisted living in elderly housing sites have been issued. Personal care is covered in adult care homes through Medicaid.	Multiple settings.
North Dakota	Assisted living services are funded through the state's Medicaid waivers and two state funded service programs.	Service model in apartment settings.
Ohio	Legislation was passed in 1993. Regulations implementing the bill were postponed pending review by a special committee in 1994. Legislation passed in 1995 repealed the statute, and authorized funding for 1300 assisted living Medicaid waiver slots effective 7/96. New rules governing residential care facilities were effective September 1996 and a decision on submitting the Medicaid waiver has been delayed pending a study of the entire Medicaid program.	Services model (waiver).
Oklahoma	A task force has been created to develop assisted living recommendations. A draft bill has been circulated and is being revised by the task force.	Service model.

Assisted Living At A Glance: Status of State Activities		
State	**Status**	**Model[1]**
Oregon	Program rules operational. Supply continues to expand with 69 facilities and 3200 units licensed and 30 projects in the pipeline.	New housing and services model.
Pennsylvania	Personal care homes are licensed. The licensing agency and interest groups are considering renaming the category as assisted living while other groups support creating a separate category with a higher level of care.	Board and care.
Rhode Island	About 45 residential care and assisted living facilities are licensed. Newer buildings offer units with private bath.	Institutional model.
South Carolina	A task force has been formed. A report is expected in the fall, 1996.	Board and care.
South Dakota	Assisted living category exists in statute. Limited services allowed.	Institutional model.
Tennessee	Legislation creating assisted living was passed in 1996. A task force has been appointed to draft regulations.	TBD
Texas	Assisted living has been added to the Medicaid HCBS waiver. A task force was formed to develop regulations creating a new licensure category. The report made changes in the existing category but did not develop assisted living recommendations.	Multiple settings.
Utah	Program rules were approved in 1995. Rules governing the buildings were also approved by a state board. An amendment to the Medicaid HCBS waiver to cover assisted living is being considered.	Multiple settings.
Vermont	The 1997 budget allows transfer of the Medicaid equivalent of 46 beds for community care and assisted living. The Department of Aging & Disabilities has formed a work group to draft the assisted living component of the program. In addition the Department has implemented an enhanced residential care facilities program which provides $50/day for 70 residents who meet the nursing home level of care criteria.	Board and care.
Virginia	Regulations allowing assisted living services in adult care residences were effective in February 1996.	Institutional model.
Washington	Rules covering assisted living as a Medicaid waiver service were issued 6/96. The 1995 budget transferred funding for 1600 NF beds to assisted living and community options. Medicaid has contracted with 70 facilities and serves 750 waiver clients.	New housing and service model.
West Virginia	Licenses personal care homes. No assisted living activity.	Board and care.

Assisted Living At A Glance: Status of State Activities		
State	**Status**	**Model[1]**
Wisconsin	Legislation certifying assisted living facilities and providing funding for a Medicaid HCBS program was passed in 1995 as part of the governor's budget. Regulations are being reviewed by the legislature. A Medicaid waiver will be submitted when the rules are approved.	Service model in purpose built apartment settings (waiver).
Wyoming	Regulations upgrading board & care rules were issued. New rules allow skilled nursing and medication administration.	Institutional model.

1. The model category refers to states with existing or pending rules implementing an assisted living program. See page 9 for further discussion. Board and care refers to states with an existing generic category which are not developing assisted living or states working on assisted living whose model cannot yet be determined.

Institutional model means a state that uses the term assisted living whose rules have more in common with board and care rules.

The new housing and service model licenses or certifies facilities providing assisted living services in apartment settings.

The service approach focuses on the provider of services which may be provided in multiple settings.

States to Watch in 1997	
State	**Activity**
Alabama	Report from State Health Coordinating Council
California	Report and draft legislation
Delaware	Task force recommendations and legislative action
Hawaii	Implementation of regulations, Medicaid waiver submission
Idaho	Recommendations from state agencies
Illinois	Implementation of pilot projects
Indiana	Task force recommendations
Iowa	New regulations
Kansas	New regulations effective
Kentucky	New regulations
Louisiana	New regulations
Maine	New regulations
Maryland	New regulations
Nebraska	Regulations from Health Department
New Jersey	Possible new rate methodology
New Mexico	Possible new rate methodology
Oklahoma	Legislative action
Pennsylvania	Recommendations for changes in regulations
South Carolina	Task force recommendations
Tennessee	New regulations
Vermont	Task force recommendations and regulations
Wisconsin	New regulations

Methodology

This component of the national study was designed to describe and analyze state policies concerning assisted living. To obtain information for this study, the authors contacted each state to update information on existing assisted living programs, to identify states that have passed new legislation or issued draft or final regulations and to obtain information concerning board and care arrangements in states that do not have or are not developing an assisted living policy. The information was collected between June and September 1996.

Telephone interviews were conducted with appropriate staff in each of the 50 states. Phone calls were made to state Departments of Health, Aging and Medicaid to determine whether laws have been passed to create an assisted living licensure category or program, whether regulations have been drafted' or promulgated, or, if no policy or legislation exists, whether a process is underway to develop and recommend policies. Copies of legislation, draft regulations, final regulations and reports were received and used as the primary sources of information for this report. Follow-up calls were made to states that were in the process of developing recommendations, issuing draft regulations or finalizing regulations just prior to publication in order to present the most up-to-date information available.

Summaries of each state's policy concerning assisted living and board and care are presented. The 1995 Guide to *Assisted Living and State Policy*[2] contained descriptions of the sources of financing for the services and housing components of assisted living. Since there have not been significant changes in the sources of financing for the services component, this report does not include that information. A later repot-t prepared by Lewin/VHI under this project will describe the sources of financing for the housing component.

The challenge grows - what is assisted living?

A common definition or understanding of assisted living grows increasingly

[1] Several states have developed draft regulations which have not completed the public process and may be altered from what appears in this repot-t. The states have been included to present information on the direction of the state's policy.

[2] For a review of the sources of financing, see Robert L. Mollica, Keren Brown Wilson, Barbara Ryther, Heather Johnson Lamarche. "Guide to Assisted Living and State Policy," National Academy for State Health Policy. Portland, Maine. May, 1995.

unlikely as state policy makers, regulators, legislators, consumers and providers develop models that address local circumstances, In a sense, describing assisted living is like finding the right term to describe a nutritious object like grapes. Like assisted living, grapes are definable yet there are many different varieties - red and white grapes, table grapes and wine grapes. There are multiple varieties of grapes (eg., cabernet, merlot, cabernet franc, sangiovese, petit verdot and many others). If you think of assisted living in these terms, models vary as well. Variations affect room/unit size, the number of units, scale of the facility, service options, delivery arrangements and pricing to name a few. Facilities might all be purpose built (eg., constructed as assisted living) and care for residents with a range of services needs. States that developed assisted living earlier than others had a specific model in mind to offer assisted living as a home-like residential alternative to nursing homes.

Assisted living might also be viewed as a series of circles or rings. The innermost circle represents a core set of characteristics (purpose built facilities, apartment settings, personal care and skilled services and a philosophy that stresses resident involvement). The second ring might provide shared occupancy in purpose built settings, while successive rings would offer services in both purpose built, board and care settings, and subsidized elderly housing and lower levels of service.

In an era of criticism of government and regulation, proponents of broader definitions of assisted living seek flexibility and opportunities to innovate. Citing the development of highly regulated nursing homes as an example, people involved in developing or shaping state policy have called for avoiding strict regulations that might limit innovation and diversity of options in the future.

Some would, therefore, prefer a concept that is broader than “grape” and prefer a term that allows for more variation - fruit. Assisted living under this concept would include purpose built projects as well as elderly housing projects in which some residents need a combination of health and supportive services but other residents are fully independent and live in “an apartment building.”

Still others want an even broader concept and would refer to grapes as a food. This category includes all forms of housing with minimal to extensive services - purpose built residences, elderly housing, board and care, boarding homes, adult family care and even retirement housing (housekeeping, one meal a day). As “food,” assisted living is defined minimally by regulations and additionally by marketing and advertising which makes it more difficult to identify and compare options.

What explains this dynamic? Over time, assisted living grew in popularity and caught the imagination of investors, consumers, housing managers and advocates. As

a term, if not a concept, assisted living has appeal at a time when many seek alternatives to nursing homes which they view as costly, institutional, overly medical model that does not offer choice. Yet, in-home services programs no longer win the immediate support that they did during the late 1970s and 1980s. Budget conscious officials question whether in-home services substitute for nursing home spending and are used by people who would otherwise remain in the community. As states reduced spending, state funded in-home programs and Medicaid waiver programs in many states did not receive additional funding to address the growing numbers of elders and people with disabilities that needed services.

Assisted living seems to have become both a new option to nursing home admission for frail elders as well as a popular vehicle to meet pent up demand for supportive services, personal care and skilled nursing services in subsidized elderly housing settings. Assisted living is a strategy for providers, consumers and advocates to expand funding for home and community based services. As a result, the concept of assisted living has been broadened in some states to encompass settings in which residents could also receive in-home services from either state funded home care programs or Medicaid home and community based waiver services programs.

Broadening the settings also expands and re-directs the flow of funds directly to providers. Elderly housing and congregate housing sites, which have been major sites for the delivery of services through in-home programs in many states, have seen Medicaid waiver or state home care budgets reduced or level funded at a time when more and more residents need services. While not necessarily a stated goal of proponents, the increasing interest and support for assisted living and its expansion to include services in these settings, housing sites may be able to supplement the funding available for in-home service programs that have been level funded in recent years. Further, most state home and community services programs are administered through independent case management systems. These systems, operated by Area Agencies on Aging, regional or field offices of state agencies or county departments, contract with providers to deliver services. Elderly housing managers are dependent on adequate funding, independent case management agencies and outside provider agencies to meet the needs of their tenants. Some housing operators would prefer to receive the funding directly and to hire staff or contract with the provider agencies. Receiving direct funding gives added control to housing managers and avoids delays in initiating services when other community programs have waiting lists due to funding constraints. As a popular trend, state legislatures may be more receptive to approving funds for assisted living than expanding existing programs.

Role of provider associations

State provider associations have had a major impact on the scope of legislation and regulations. State association members, directors and staff of the state Health Care Associations, Homes and Services for the Aging, chapters, Assisted Living Federation of America and Home Care Associations, representing certified home health agencies, have been very active in shaping public policy. While the positions of each association vary from state to state, the battle lines have frequently been drawn by nursing home representatives seeking to prohibit assisted living policy from providing nursing services, and sometimes personal care, in a residential setting. States in which a significant percentage of health care association members also operate, or plan to develop, assisted living projects have been less likely to oppose assisted living legislation. Assisted living is viewed either as a competitive threat or an opportunity by nursing home and board and care owners/administrators. The prevailing perspective will determine positions on the definition, the admission and retention criteria and the level of service that can be provided. States with very active home health care associations have lobbied for requiring any skilled or medical services (therapies) to be provided by a certified home health agency rather than registered nurses hired or contracted by the facility.

The pace of state action may also be influenced by the tendency among states to respond in groups to new trends. State activity parallels state initiatives in health care reform. A small number of states acted first on new ideas and introduced new approaches to providing services. Their initiatives divert markedly from earlier approaches to solving problems. In the late 1980s and early 1990s, Hawaii, Massachusetts, Minnesota, Oregon, Vermont and Washington and other states developed approaches to achieve universal coverage, expand access for low income residents, stabilize private health insurance markets through reforms and subsidies, and simplify and expand Medicaid eligibility. A second group of states followed with more modest but significant reforms (insurance market reforms, Medicaid managed care) while a third group either did not enact any reforms or pursued more limited approaches to changing the health care system.

Although smaller in size and scope than state health reforms, there seem to be a similar grouping of states implementing assisted living models. Again, a small number of states adopted assisted living in the late 1980s to mid-1990s as a bold and different approach to providing long term care. This group was followed by a larger number of states that either learned from the experience of the initial states or pursued a different model for action. In the third group of states, public policy makers have either not yet initiated any reforms or are responding to initiatives emerging in the market. As with health care reform, there appear to be observable differences in

the approaches implemented by states in the later phases of this national movement.

In the absence of a national initiative, and in view of the differences among states as well as the tendencies of state leaders to respond differentially to new ideas and trends, it is unlikely that any single concept, model or definition of assisted living will emerge. In the private insurance market, it is easier to achieve standardization of state policies than in other areas (Medicaid, uninsured, health subsidy initiatives). The National Association of Insurance Commissioners creates committees to develop model guidelines for states to adopt in both the individual and group health insurance market. While many states exceed the guidelines, others adopt the model or components of it.

As yet, there is no process that is similar to the NAIC model to help state assisted living policy development. Instead, an informal network has emerged as state agency staff identify key contacts in states that have adopted policy to learn from their experience, to help develop policy options and to obtain language that might be adopted or modified to fit state needs.

Market dynamics - some observations

During the course of the study, the authors spoke with many state representatives about the dynamics in their states. We also spoke to operators and state association staff in some states and developed some observations that highlight interesting features of the developing assisted living market. These observations are often anecdotal and are not supported by research data. While they may not be generalizable, they suggest the difficulties faced by state policy makers and regulators seeking to implement a vision or set of principles through public policy.

Regulations set parameters for what is possible. Admission/retention criteria establish the maximum boundaries for tenants and the service provisions define the maximum allowable package that may be delivered. Operators are still able to determine which tenants may be admitted or retained and what services are provided. Regulations often specify that the residence must develop written policies concerning whom it will serve and what services will be provided. As a result providers may choose not to offer all the services allowed by regulation. Companies that own or manage assisted living facilities and nursing homes may view the nursing facility as their primary line of business and develop assisted living as a referral source. While this policy may be a sound business strategy, it is not consumer or customer focused and does not maximize a resident's ability to age in place.

Despite broader rules, facilities may be successful at offering a limited service

package. If competition is limited, and demand and occupancy are high, facilities can operate successfully offering limited services. The staffing requirements are easier to manage and rates can be relatively low. As more facilities locate in an area and residents age and require more services, these facilities will have a more difficult time maintaining a lower service package. If as residents leave, new residents are harder to attract, the residence will have to increase the service intensity to retain residents rather than allow a lower occupancy rate.

Providers seek protection for the product they market today. New assisted living licensure categories which require more privacy and autonomy may displace older shared occupancy models. Providers who build new facilities that reflect current consumer preferences face challenges for what to do with an existing facility. Can it be sold, rehabilitated or converted to another use? If not, is the organization solvent enough to withstand its closing?

Single occupancy apartments or rooms would appear to dominate the private market. As the upper income market becomes saturated and more companies seek to serve low and moderate income elders, efforts to develop “affordable” models may compromise on single occupancy. Medicaid policy will play a critical role in shaping the market over time as it serves lower income residents. Facility operators quickly identify shared occupancy as the only way to develop affordable units. While historically low Medicaid rates are cited as the reason for offering double occupancy, owner pricing policy also plays a role. Offering double occupancy allows setting higher prices for single occupancy and scaling prices by room size. The actual cost difference of single versus double occupancy units over the life of a mortgage is minimal. However, the revenue stream that can be generated by shared occupancy may be significant. Some providers contend that shared occupancy models actually require more staff time than single occupancy units because of the problems and conflicts that must be resolved. Under the guise of affordability, developers may market shared occupancy models to lower income residents. Thus far, Medicaid policy in several states has recognized both the importance of single occupancy in fulfilling the principles stated in their policy and developed a reimbursement level that allows facilities to contract with Medicaid at the market rate. Other states have required apartments but do not specify that apartment units can be shared only by choice. Whether Medicaid’s role in maintaining the apartment and single occupancy threshold for low income residents continues remains to be seen.

While Medicaid policy makers are concerned about rising nursing home spending, except in Massachusetts, they have not developed assisted living strategies that target elders with incomes just above Medicaid eligibility. Many states have not used their flexibility under Medicaid eligibility rules to allow recipients with income

between Medicaid eligibility and around 45% of median income (300% of the federal SSI benefit) to afford assisted living. In areas where the room and board charges exceed the typical income of a person just above Medicaid eligibility, adopting the 300% eligibility option and setting a higher maintenance threshold allows people who qualify for admission to a nursing home to become eligible for Medicaid waiver services in an assisted living setting. Without such options, elders with incomes above Medicaid and below about 45% of median income will quickly spend down in a nursing home. As states examine Medicaid long term care spending and develop strategies for offering more home, community based and residential alternatives, the 300% option may become an important resource.

Overview

Despite the continuing confusion and differences among states, state activity has increased since 1994. Thirty-one states have taken steps to implement an assisted living policy and 13 others have instituted a process to study the issue.[3] In 1995 and 1996, laws were passed in Arizona, Hawaii, Iowa, Kansas, Kentucky, Maryland, North Carolina and Tennessee. Legislation amending previous law passed in Florida and Maine. Regulations are being developed for comment by the Louisiana Department of Social Services.

The Arizona legislature passed legislation expanding a pilot supportive residential living program under the state's Arizona Long Term Care System (Medicaid) statewide after an evaluation found that the program was cost effective. Hawaii's legislature authorized the development of assisted living regulations in 1995. Regulations have been issued for comment.

The Iowa legislature passed a law creating a certification process for assisted living. Rules are being developed which will certify facilities providing home-like environments and follow the principles of assisted living. The state fire marshall will develop fire and safety standards.

Regulations in Kansas were being readied for publication and a Medicaid HCBS waiver has been submitted that allows assisted living facilities to become providers of waiver services. Kentucky's law will create apartment or home-style housing units in assisted living residences. Regulations in Tennessee will be developed by a 13 member task force headed by a state agency. Unit requirements and

[3] Several states with existing policy have formed a task force to review the policy and make recommendations.

admission/retention criteria will be developed by the task force.

Maryland's approach will broadly define assisted living as a program that provides housing and supportive, health related and other services. Regulations will be drafted which allow residents to age in place in a variety of settings.

North Carolina also crafted assisted living as a broad umbrella covering board and care and multi-unit assisted housing with services. The law describes two categories of assisted living residences: adult care homes (formerly domiciliary homes) and multi-unit assisted housing with services. The law allows adult care homes to provide services with their own staff but personal care and skilled nursing services delivered in multi-unit assisted housing with services settings must be provided by a licensed home health, home care or hospice agency. Assisted living residences include a range of living units - private apartments, private rooms with private or shared baths and shared rooms with private or shared baths.

Ohio has developed regulations changing the name of their board and care model from rest homes to residential care facilities. The legislature had authorized the development of a Medicaid HCBS waiver to implement an assisted living model. The waiver application has been delayed pending a review and potential restructuring of the state's entire Medicaid program.

Washington, which originally implemented a pilot program using Medicaid contract specifications, has issued Medicaid regulations governing contracts with boarding homes that are interested in providing assisted living. Washington does not license assisted living separately and has developed regulations to purchase assisted living from licensed boarding homes.

To summarize state activity[4]:

- Twenty-one states had existing regulations or Medicaid provisions using the term "assisted living" as of October 1996.
- Nine states were drafting rules after passing new legislation.
- Twenty-two states provide Medicaid reimbursement for assisted living.
- An additional six state Medicaid programs cover services in board and care

[4] States may be counted in more than one category.

settings but do not use the term assisted living (Colorado, Georgia, Missouri, Montana, Nevada and Vermont).

- Thirteen states have formed a task force or are otherwise studying assisted living.

- Ten states have only board and care rules and are not actively planning to develop an assisted living policy.

State models

Compared to the Academy's 1995 assisted living study, categorizing state models was more complex. The 1995 Guide analyzed policies, statutes and regulations in states using the term "assisted living." Based on the analysis of assisted living models, a three part framework was devised that reflected state approaches to licensure, unit requirements and service level. The three approaches were:

- Board and care/institutional
- New housing and services model
- Service model.

Institutional models allow shared bedrooms without attached baths and either do not allow nursing home eligible residents to be admitted or do not allow facilities to provide nursing services. Two states, Alabama and Rhode Island, adopted "assisted living" as the name for their board and care licensure category. South Dakota and Wyoming re-named an existing licensure category as assisted living and allowed a higher level of service to be provided without changing the unit requirements. Some states allow skilled nursing services to be provided for limited periods by a certified home health agency. The upgraded board and care approach recognizes that residents are aging-in-place and need more care to prevent a move to a nursing home. State policies have allowed these facilities to admit and retain people who need assistance with activities of daily living (ADLs) and some nursing services. Mutually exclusive level of care criteria have been revised to allow people who would qualify for admission to a nursing home to be retained. The model retains the minimum requirements for the building and units (usually multiple occupancy bedrooms with shared bathrooms and tub/shower areas).

The new housing and service model licenses or certifies facilities providing assisted living services which are defined by law or regulation. These models require apartment settings and allow facilities to admit and retain nursing home eligible tenants. State policies often include a statement of philosophy that emphasizes

resident autonomy and creates a prominent role for residents in developing and delivering services. Licensing the setting and services defines assisted living separate from board and care and states have attempted to develop more flexible regulations.

The final category captured a new trend among states to focus on the service provider, whether it is the residence itself or an outside agency, and allow existing building codes and requirements rather than new licensure standards to address the housing structure. This model simplifies the regulatory environment by focusing on the services delivered rather than the architecture. Unfortunately, newer residential models serving frailer residents are not as familiar to local building inspectors and code enforcement officials who may want to apply more institutional requirements than are needed. Service regulation approaches may include requirements that define which buildings (apartment units, minimum living space) may qualify as assisted living but the licensure agency's staff do not otherwise apply their standards to the building's characteristics.

The service model is more appropriately divided into multiple settings and services in apartment settings. States which have developed multiple setting approaches may license the service provider in a conventional elderly housing or congregate housing site as well as settings which may be licensed under residential care or board and care categories. States representing this approach include Alaska, Maine, Maryland, New Jersey, New York, North Carolina, Utah and Texas.

Several states license, or provide Medicaid reimbursement for, assisted living as a service and also set minimum criteria for qualifying buildings, such as apartments or private rooms with baths, but do not separately license the building. Connecticut, Minnesota, North Dakota and Wisconsin's pending regulations follow this model.

State models were developed to meet defined needs in different settings. A state's policy may address needs in more than one setting. Housing and service models serve elders who often live alone and need assistance during the night. Home and community based services program generally are not able to provide care during evening and night time hours because of the cost and relatives or other caregivers are not available. Without such an option, these elders would most likely move to a nursing home.

The "multiple settings" model also addresses aging-in-place in both board and care and larger elderly housing projects. Residents in both settings are aging-in-place. A higher level of service may be available in settings which were previously licensed as board and care. In addition, similar services are provided in a supportive housing program to residents in conventional elderly housing. In these settings, some tenants

may be totally independent and do not receive assisted living services while others require assistance with IADLs, ADLs and health care needs.

What about services in elderly housing?

Questions can be raised about approaches that regulate the service rather than the setting. In some settings, differentiating assisted living from more common community based services programs becomes difficult. As a new trend, the term "assisted living" should mean something different from board and care or in-home services models of care. Policy makers need to respond to aging-in-place that is occurring in conventional elderly apartment complexes since many residents have both health and personal care needs. The key question is: when does an apartment building become an assisted living residence? For residents who are receiving personal care and some nursing care, elderly housing may resemble buildings that were designed and built as an assisted living residence. For independent residents, it's an apartment building. Even if all the residents required some supportive services, many contend that the building would not constitute an "assisted living" site because of licensure and architectural characteristics.

There are two options for licensing assisted living as a service. The first approach includes new construction or renovation of a building that is designed to serve frail residents. The term is clear as it refers to a building in which all the residents receive some level of care. Buildings which are built explicitly to operate as assisted living settings can be built to existing codes for multi-unit residential environments. Some contend that in states that permit or require the assisted living setting to care for residents with nursing home level needs (skilled services), a more institutional code might be necessary. Others disagree. However, all residents will require some level of service on admission and the state agency licenses the service component.

The second approach also licenses assisted living as a service that can be provided in a conventional elderly apartment complex. To some extent, existing elderly housing buildings can also be considered assisted living. Because a significant percentage of, but not all, residents need service, the assisted living component may be considered a more comprehensive, organized service package provided in subsidized housing with a mix of residents, some of whom are impaired and others who function independently. In this setting comparisons with in-home service programs and confusion between independent and dependent residents concerning the type of building they live in is more likely.

The important factor is that residents receive the service they need to maximize

functioning in the most independent and autonomous way possible. Whether the term "assisted living" is applied broadly or more narrowly may be a function of the presentation of the concept in a way that generates the level of political support to make the resources available. Regarding assisted living solely as a service, not a place, may omit setting important requirements for living units. In licensing or certifying assisted living as a service, however, state regulations can require that assisted living services be provided in buildings with apartments or private rooms and attached baths while still allowing state and local building codes to govern the structure itself. Connecticut, New Jersey (assisted living program category) and North Carolina (multi-unit housing category) are examples of this approach.

The first approach is more compatible with the model developed by states that license both the service and the setting as assisted living (e.g., Oregon). The second approach straddles an area between assisted living (philosophy, on-site staff, ability to meet unscheduled needs) and an in-home service program (e.g., Connecticut, New Jersey, North Carolina). Housing providers dealing with aging-in-place may resist presenting their building as an "assisted living" residence because of the presence of independent residents and the impact such a term has on marketing vacant units to new residents. Determining the state's approach requires distinctions between purpose-built housing (eg., housing built specifically to serve as assisted living) and elderly apartment complexes which have experienced a significant degree of aging-in-place and demand for in-home services.

Participants at a 1995 round table on assisted living discussed the environmental differences between conventional elderly housing and assisted living. Buildings designed and built as assisted living tend to have higher lighting levels in common spaces, more common spaces for activities and socialization, different flooring, small refrigerators raised above floor level, handicapped accessible bathrooms in every unit, roll-in showers, wider corridors with hand rails, two way voice communication and other features. Conventional elderly housing generally may not have been renovated to accommodate the decreasing independence of residents needing care.

However, New Jersey defines assisted living as "a coordinated array of supportive personal and health services, available 24 hours per day to residents who have been assessed to need these services including residents who require formal long term care." Assisted living services can be provided in three settings: assisted living residences, comprehensive personal care homes and assisted living programs. The assisted living program model is provided in elderly housing projects. New Jersey sought to develop a model that is suitable for urban environments, assuming that limited land availability and high costs will limit new construction in major cities. To

develop its assisted living program model, the state funded a two year pilot project in a large elderly housing site. Prior to the pilot, residents who needed assistance received one meal in a congregate dining room, one or two hours of housekeeping a week, laundry and shopping.

As part of the pilot, personal care, additional meals, medication assistance and escort services to doctors appointments were added and wellness and health education programs (flu shots, health fair, guest lectures, referrals to podiatrists, dentists and physicians) were available to all tenants. In addition, a health clinic was established using a vacant apartment that was staffed by a geriatrician and a geriatric nurse practitioner two and a half days a week. Security guards were used to implement a 24 hour emergency response capacity. Twenty-four hour on site staff coverage was not identified as a need. Twenty five percent of the participants met the nursing home admission criteria. The evaluation found the program was cost effective, consumer centered and worthwhile.

Based on the results, regulations were drafted and issued for public comment. The New Jersey rules now refer to assisted living residences (purpose built facilities), comprehensive personal care homes (previously licensed homes which meet new standards) and assisted living programs which are services provided to residents in publicly subsidized housing sites. State officials expected the regulations would take effect January 1, 1997.

North Carolina has recently issued requirements for registration and disclosure for a category of assisted living residences called multi-unit assisted housing with services. Services in these settings are arranged by housing management but provided by a licensed home care or hospice agency and not the housing provider, unless the housing management company is also licensed as a home care agency. The disclosure statement describes the services which may be arranged, the cost of services, tenant admission/retention criteria, a list of service providers, a grievance procedure and any financial relationships between service providers and the housing management. This category seems to formalize but not alter the existing in-home delivery system serving residents in elderly housing sites.

While the primary vehicle for reimbursing care in residential settings is through the Medicaid state plan, the combination of rules and Medicaid funding create some interesting contrasts. North Carolina reimburses assisted living residences in adult care homes and multi-unit assisted housing with services models. Personal care in adult care homes is reimbursed as a state plan service while the Medicaid HCBS waiver may cover eligible residents in multi-unit assisted housing with services settings. Participants must meet the nursing home level of care criteria while adult

care home residents must have ADL impairments. It has not been determined whether residents in subsidized elderly housing sites which register as multi-unit assisted housing with services settings will be eligible for both programs,

States designing policies to facilitate aging-in-place must recognize the importance of meeting unscheduled needs for personal care, especially during the night, holidays and weekends. In terms of capacity to serve frail residents, these are key variables. Whether services are provided directly by the building management or through a contract to serve all residents with a community agency (certified home health agency, licensed home care agency) is less significant than the availability of 24 hour staffing capacity and the ability to meet unscheduled needs for assistance with activities of daily living. Issues of cost are also significant. A certified home health agency may have a higher cost structure in order to maintain its Medicare certification which adds to the cost of delivering services. Home health agencies which have created home care subsidiaries can deliver a similar level of care with lower costs.

Assisted living is thriving in many states that have not created an assisted living licensure category or program. In some instances, assisted living facilities are not required to be licensed and in other states, facilities marketing themselves as assisted living are licensed under the state's board and care (or equivalent) guidelines.

Differentiating assisted living from independent elderly housing and board and care may help consumers understand the different service options and establish assisted living as a new "product." However, bringing a new model to urban areas will be difficult and developing assisted living where many low income elders live may force policy makers to consider elderly housing as a "naturally occurring assisted living community." Housing construction and rehabilitation financing sources might consider making loans to housing development owners that modify the physical environment to accommodate the needs of a frailer resident population.

Alternative classification schemes

The current study examined assisted living more generically and compared assisted living and board and care in all 50 states.[5] Further analysis of state policies suggests that the original categories (new housing and service model, service in multiple or apartment settings and institutional model) may be simplistic and ignore the complexities of state **policy.** We have **compared states according to several variables:**

[5] Board and care is used to refer to residential care facilities, boarding homes, personal care homes and similar terms.

- the licensing approach (apartments only, multiple or apartment and non-apartment settings, services in apartment settings, institutional and board and care);

- availability of Medicaid reimbursement and licensing; and

- unit or occupancy requirements.

Based on this broader review of state policy, we have identified five paths that states have taken (see Table 3):

- Licensure or Medicaid reimbursement as an **apartment setting** in which specified services are provided;

- Licensure or Medicaid reimbursement as a service which may be provided in **multiple settings** specified in the regulations which may or may not be licensed as assisted living including board and care;

- Licensure or Medicaid reimbursement as **a service in an apartment setting;**

- Licensure or Medicaid reimbursement as a **generic "board and care" or institutional** model using the term assisted living; and

- No specific assisted living category but facilities meet **board and care** licensure requirements.

Medicaid status

A categorization system based on licensure alone is not sufficient since twenty one states also cover assisted living as a Medicaid service (state plan, HCBS waiver or 1115 waiver). Twenty-two states reimburse or purchase assisted living under Medicaid. Eight of these states do not have a separate licensure category. In these states, assisted living residences contracting with Medicaid programs may be licensed under a generic board and care category and meet further requirements established by the Medicaid agency or the residences may operate as conventional elderly housing projects. (See table 4.)

Medicaid programs in Arizona, Minnesota, North Dakota and Washington contract to serve nursing home eligible residents with facilities licensed under general board and care rules but which meet additional standards (usually providing

Table 3. State approaches[2]					
Assisted Living				Board and Care	
Apartment setting	Multiple settings	Services - apt. setting	Institutional		
Arizona	Alaska	Connecticut	Alabama	Arkansas	Missouri
Hawaii"'	Florida	Minnesota[3]	Rhode island	California	Nebraska
Iowa[1]	Kentucky"'	North Dakota	South Dakota	Colorado	Nevada
Kansas"'	Maine	Ohio[5]	Virginia	Delaware	Montana
Louisiana")	Maryland	Wisconsin(')	Wyoming	Georgia	New Hampshire
New Jersey[4]	Massachusetts			Idaho	Pennsylvania
Oregon	New Mexico[9]			Illinois	South Carolina
Vermont[8]	New York			Indiana	West Virginia
Washington[3]	North Carolina			Michigan	
	Oklahoma[7]			Mississippi	
	Texas				
	Utah[6]				

1. Based on legislation or draft regulations.
2. Legislation did not specify the requirements in Tennessee.
3. Created through Medicaid Home and Community Based Waiver Services Programs.
4. New Jersey provides services in multiple settings but each newly constructed facility participating in the assisted living services program must meet apartment standards.
5. Based on a proposed Medicaid waiver program that has not been implemented.
6. Provides for both apartments and bedrooms with shared bathrooms and shower/tub but introduces assisted living philosophy into institutional settings.
7. Based on draft legislation to be re-filed in 1997.
8. Based on initial task force decisions.
9. Apartments or private rooms shared only by choice are required.

apartments). These states require apartment settings but build on an existing licensure category. While the model itself requires apartment settings, it does not reflect a new licensing approach. Other state Medicaid programs will contract with facilities who meet service requirements but are not required to offer apartments. Texas has three

types of providers: those offering apartment settings, double occupancy apartments and double occupancy non-apartments. Alaska, Utah and Virginia will contract with facilities that have apartments or shared rooms.

While most states have used the Medicaid Home and Community Based Services Waiver program, Maine, Massachusetts, North Carolina and New York cover assisted living as a state plan service. New York has limited the number of contracted units to 4200 and has reduced the nursing home bed need formula by 4200 beds. New York has "bundled" a number of state plan services (home health aide, therapies, skilled services, durable medical equipment) and provides a monthly capitation payment based on the equivalent, case mix adjusted, payment in a nursing home.

Table 4. Medicaid status and assisted living

Assisted living		Medicaid in board and care
License and Medicaid reimbursement	**Medicaid Only**	
Alaska	Arizona	Colorado
Florida	Illinois[5]	Georgia
Hawaii[1]	Minnesota	Missouri
Iowa[2]	New Mexico	Montana
Kansas[1,3]	New York	Nevada
Maine	North Dakota	Vermont
Massachusetts	Texas	
New Jersey	Washington	
North Carolina		
Oregon		
South Dakota		
Virginia		
Wisconsin[4]		

1. Regulations ready to be released.
2. Law passed, regulations being developed. State intends to seek Medicaid reimbursement.
3. Waiver request submitted to HCFA.
4. Decision on regulations and Medicaid waiver program pending.
5. Pilot project being developed.

Massachusetts created a group adult foster care program as a state plan service and provides a rate to qualified providers. The service is covered in the state plan as an ambulatory service. North Carolina reimburses personal care in assisted living (adult care homes) as a state plan service. Since 1990, Maine has reimbursed personal care services in "private non-medical institutions" which are licensed as residential care facilities. The legislature approved funding for 75 units of assisted living as a pilot project in 1996. Officials are considering the implications of new assisted living rules on the current reimbursement policies.

Colorado, Georgia, Missouri, Montana, Nevada and Vermont provide Medicaid reimbursement in facilities licensed as board and care homes but do not use the term assisted living in their Medicaid programs.

Building on table 4, we have added further dimensions to approaches taken by states and compare states based on their licensing and Medicaid reimbursement policy. We have grouped states into five categories relative to assisted living (see table 5):

- States that license/certify all facilities called assisted living;
- States that license assisted living and provide Medicaid reimbursement;
- States that provide Medicaid reimbursement but do not have a licensure category for assisted living;
- States that have task forces that are developing assisted living policy options or recommendations;
- States with no activity.

Among the states that license and/or reimburse assisted living, several have recently passed legislation and are still developing regulations (eg., Hawaii, Iowa, Kansas, Kentucky, Ohio, Tennessee, Wisconsin).

Column 1 includes states whose rules apply to all facilities licensed as assisted living. Column 2 includes states whose **rules apply to all facilities licensed as assisted living and reimbursement is provided through Medicaid. Column 3 lists states whose rules or policy** only applies to assisted living facilities that contract with Medicaid. Facilities which do not contract with Medicaid are not covered by the regulations and may, depending on their service package and the manner in which services are delivered, be licensed under general board and care regulations. Column **4 identifies**

states that have formed a task force, work group or other process to develop assisted living recommendations.

As states consider developing assisted living for other population groups, the concept undergoes even further adaptation. For, example, Arizona and Vermont are examining the development of assisted living for adults with physical disabilities. The principles of the independent living movement and the focus on consumer directed attendants means allowing assisted living residents the opportunity to hire and supervise their own attendant in an assisted living setting. State policy makers seeking

Table 5. Comparison of State Assisted Living Regulations and Medicaid Financing

License all facilities	License and Medicaid reimbursement	Medicaid only	Task force/ studying
Alabama	Alaska	Arizona	Alabama
Connecticut	Florida	Illinois[4]	California
Louisiana[3]	Iowa[3,6]	Minnesota	Delaware
Kentucky[3]	Hawaii[1]	New Mexico	Idaho
Maryland[3]	Kansas[1]	New York	Illinois
Rhode Island	Maine[3]	North Dakota	Indiana
Tennessee[3]	Massachusetts[6]	Ohio[2]	Nebraska
Utah	New Jersey	Texas	New York
Wyoming	North Carolina	Washington	Oklahoma
	Oregon		Pennsylvania[5]
	South Dakota		South Carolina
	Virginia		Texas
	Wisconsin[2]		Vermont

Notes:
1. Regulations ready to be released.
2. Decisions on regulations and/or Medicaid coverage pending.
3. Regulations being developed.
4. Pilot being developed.
5. No formal task force. Licensing agency is reviewing options and may prepare a proposal.
6. Certify rather than license facilities.
7. Does provide Medicaid reimbursement in board and care settings.

to balance responsiveness to consumers and advocates with spending priorities and consistent program models are being challenged to develop policies and regulations that maintain program boundaries yet build sufficient support (or avoid opposition) to enable passage and implementation of new initiatives.

Differences between assisted living and board and care

Defining and differentiating assisted living from board and care has plagued the development of assisted living in recent years. There is some overlap between board and care and assisted living rules. A review of state polices finds that four states use assisted living and board and care interchangeably - Alabama, Rhode Island, South Dakota and Wyoming. However, state assisted living policies generally differ from board and care rules in three primary areas:

- Assisted living statutes/regulations often contain a statement of philosophy that emphasizes privacy, independence, decision-making and autonomy.

- Assisted living is more likely to emphasize apartment settings shared by choice of the residents.

- Assisted living allows facilities to provide or arrange nursing services and to admit or retain residents who may meet the level of care criteria for admission to a nursing facility.

Assisted living and board and care - Washington			
Component	**Assisted living**	**Enhanced adult residential care**	**Adult residential care**
Room and board	Yes	Yes	Yes
Personal care	Yes	Yes	Yes
Nursing services	Yes	Yes	No
Private unit	Yes	No	No
Private bathroom	Yes	No	No
Kitchen	Yes	No	No
Nurse delegation	**Yes**	**No**	**No**

Washington state has developed regulations which differentiate assisted living,

residential care and enhanced residential care. Assisted living contractors must offer private apartments and may provide limited nursing services. Enhanced adult residential care providers may provide limited nursing services while adult residential care contractors may not. Adult residential care and enhanced adult residential care providers are not required to offer private units with bathrooms and kitchens.

Philosophy

To many people, assisted living represents a more consumer focused model which organizes the setting and the delivery of service around the resident rather than the facility. States which emphasize consumers use terms such as independence, dignity, privacy, decision-making and autonomy as a foundation for their policy. States which have adopted or proposed this philosophy are Arizona, Florida, Hawaii, Illinois (draft bill), Iowa, Louisiana, (preliminary draft), Maryland, Massachusetts, New Jersey, New Mexico, Oregon, Utah, Virginia and Washington. Massachusetts includes their language in a section that allows the Secretary of Elder Affairs to waive certain requirements for bathrooms as long as the residences meet the stated principles.

Oregon's definition states that "Assisted living promotes resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and home-like surroundings." Florida's statute states the purpose of assisted living is "to promote availability of appropriate services for elderly and disabled persons in the least restrictive and most home-like environment, to encourage the development of facilities which promote the dignity, individuality, privacy and decision-making ability . .." The laws also state that facilities should be operated and regulated as residential environments and not as medical or nursing facilities. The regulations require that facilities develop policies which allow residents to age-in-place and which maximize independence, dignity, choice and decision-making of residents.

New Jersey has issued proposed amendments to their rules which emphasize the values of assisted living and introduce managed risk. Facilities must provide and coordinate services "in a manner which promotes and encourages assisted living values." Assisted living values means the organization, development and implementation of services and other facility or program features so as to promote and encourage each resident's choice, dignity, independence, individuality and privacy in a home-like environment. The values promote aging-in-place and shared responsibility.

Privacy

Privacy is primarily measured by the type of unit, the ability of residents to lock their doors and the behavior of staff. States which have based their policy on privacy

have emphasized apartments with attached bath. Autonomy is promoted by the availability of cooking facilities within the unit. Of the 30 states that have established or proposed assisted living policy in this area, the following require apartments: Arizona, Connecticut, Hawaii, Iowa, Kansas, Minnesota, New Jersey,' North Dakota, Oregon and Washington. Regulations pending in Ohio and Wisconsin allow shared rooms, however, if Medicaid coverage is sought in Ohio, it will only reimburse private units and private units will be required under Medicaid in Wisconsin. Washington requires private apartments shared only by choice. New Jersey's policy requires apartments for newly constructed units but allows two people to share an apartment. Florida now has two types of assisted living, one which allows up to four people to share a bedroom, and extended congregate care, which requires private apartments, private rooms or semi-private rooms or apartments, shared by choice of the residents. Massachusetts allows two people to share a room or apartment. Kentucky's statute requires apartments or home-style units. A home-style unit is a private room with a semi-private bathroom and use of kitchen facilities.

States which have developed a multiple setting assisted living model vary the requirements by the setting. New York allows sharing for board and care facilities participating in the Medicaid program but requires apartments in the "enriched housing category" which includes purpose-built residences and subsidized housing.

New Mexico's Medicaid assisted living waiver covers two types of facilities offering "home-like" environments which are either units with 220 square feet of living and kitchen space (plus bathroom) or single or semi-private rooms in adult residential care facilities, however, rooms may be shared only by choice.

Maine's new law allows residential care facilities and congregate housing projects to operate as assisted living. Residential care facilities may offer shared rooms and congregate housing projects are typically built as elderly housing projects. North Carolina allows up to four residents to share a room in adult care residences but the multi-unit assisted housing with services category contains apartments in elderly housing projects. Texas covers assisted living services through Medicaid to residents in three settings: assisted living apartments (single occupancy); residential care apartments (double occupancy allowed); and residential care non-apartments (double occupancy rooms). Utah also establishes separate requirements based on the units offered rather than the setting. Facilities offering apartments must be single or double occupancy with a bathroom, living room, dining space and kitchen facilities. Facilities

[6] New Jersey's rules require apartment settings for all new construction but allowed existing Personal Care Homes to convert to assisted living.

may also provide double occupancy rooms. Virginia's new rules for assisted living also build on board and care requirements which allow four people to share a room.

Policy on the living units has not been determined in Iowa, Kentucky and Tennessee.

Shared rooms, toilet facilities and bathing facilities are the rule among states with board and care regulations. Board and care rules generally allow bedrooms shared by 2-4 residents and bathrooms shared by 6-10 residents. Board and care and/assisted living rules in Alabama, California, Colorado, Idaho, Nevada, New Hampshire, New Mexico, New York, South Dakota, Utah and Wyoming limit sharing of units to two residents. South Dakota requires a toilet room and lavatory in each room. Three people may share a room in West Virginia. A few states do not specify a limit on the number of people sharing a room.

Four people may share a room under board and care rules in Delaware, Georgia, Indiana, Iowa, Michigan, Mississippi, Missouri, Nebraska, Pennsylvania, Rhode Island, South Carolina and Virginia.

Space requirements under board and care rules typically require 80 or 100 square feet for single units and 60 or 80 square feet per resident in shared units. Alabama requires 130 square feet for double units and New Hampshire requires 140 square feet. Several states with assisted living rules that require apartments do not specify a square footage (Connecticut, New Jersey), while Arizona, Oregon and Washington require at least 220 square feet of living space, not including closets or bathrooms.

Table 6 presents state policy concerning living units. States that allow shared units generally have developed policy that broadens the scope of residential options and may create two or more types of buildings, each with different requirements (eg., Florida, New York, Texas, Utah). The table may also be expressed as a continuum. On one end are residences that offer single occupancy units with kitchenette and skilled services to residents. On the other end are residences that provide shared units without cooking capacity to residents who cannot receive skilled services in an assisted living setting. While a state's policy sets the parameters for what may be offered and provided, the actual practice may be more narrow. While shared units may be allowed, the market may produce very few or no projects that offer shared units. Further, facilities constructed prior to the development of assisted living may offer shared units while most, if not all, newly constructed buildings have private units.

Table 6. State policy concerning living units'			
Assisted living		**Shared units**	
Apartments	**Multiple settings**	**Assisted living**	**Board and care**
Arizona	**Alaska**	Alabama	Arkansas
Connecticut	Delaware'	Rhode Island	California
Hawaii	Florida	South Dakota	Colorado
Kansas	Kentucky	Virginia	Delaware
Louisiana (draft)	Maine	Wyoming	Georgia
Minnesota	Maryland*		Idaho
New Jersey	Massachusetts		Indiana
North Dakota	New Mexico		Illinois
Ohio (pending)	New York		Mississippi
Oregon	North Carolina		Missouri
Vermont (task force)	Oklahoma (draft bill)		Montana
Washington	Utah		Nebraska
Wisconsin (pending)	Texas		Nevada
			New Hampshire
			Pennsylvania
			South Carolina
			West Virginia

1. Includes assisted living rules in states with existing or draft regulations and board and care rules in other states. Does not include policy in states which have established a task force or process to develop recommendations. Does not include Iowa and Tennessee since requirements have not been determined.
2. Delaware's task force report calls for covering assisted living in a range of settings. Maryland's law also assumes multiple settings.

Tenant policy or admission/retention criteria

State policy on the level of need that may be served in assisted living varies widely. In addition, state rules and actual practice may vary in the same state. Most

state rules define the conditions that residents may or may not have in order to be admitted or retained in an assisted living residence. But these standards are not required for each residence. individual residences are generally allowed to establish their own standards within state parameters and residences are required to inform prospective tenants what the policy is and the conditions that would trigger "move out." For example, Massachusetts' rules allow residences to meet personal care needs. At a minimum residences must offer support for bathing, dressing and ambulation but are not required to offer assistance with other ADLs. Most other states allow but do not require residences to serve people with ADL needs.

The broadest policy has been implemented in New Jersey. The residence may, but is not required to, care for people who:

- require 24 hours, seven day a week nursing supervision,
- are bedridden longer than 14 days,
- consistently and totally dependent in four or more ADLs,
- have cognitive decline that interferes with simple decisions,
- require treatment of stage three or four pressure sores or multiple stage two sores,
- are a danger to self or others or
- have a medically unstable condition and/or special health problems.

Assisted living in New Jersey is not appropriate for people who are not capable of responding to their environment, expressing volition, interacting or demonstrating independent activity. Each resident receives an assessment and a care plan by a registered nurse. The admission agreement has to specify if the residence will retain residents with one or more of these characteristics and the additional costs which may be charged.

Since the experience with these criteria is limited, no assessment has been made of the ability of residences to provide this level of service. Applications show a bell shaped curve with most facilities selecting 3-4 conditions which they will serve. A few on either end will not serve people with any of the eight criteria while a similar number will serve people meeting all eight criteria.

Oregon and other states have developed assisted living as the equivalent of nursing home care, at least for people at lower acuity levels. The New Jersey regulations require that at least 20% of the occupants meet the nursing facility admission criteria within three of years licensure. Tenant admission/retention criteria often result from compromises reached with trade associations. Reflecting the role of state home care associations, Massachusetts and Tennessee included requirements that all skilled services must be provided by a certified or licensed home health agency. However, most of the controversy has been sparked by drawing the line between nursing home and assisted living. State respondents reported consistent though varied opposition from nursing home operators to allowing people who need skilled services to be served. In at least one state, an association objected to the ability to provide personal care. As a result of the policy formulation and legislative process, a number of compromises have emerged. States typically include a general statement that residents must have stable health conditions and do not need 24-hour skilled nursing supervision. A number of states have specified which conditions may or may not be treated in an assisted living residence.

Nursing home providers participating on the Maryland task force sought upper limits on admission/retention criteria but the task force adopted a policy which allows residents to remain as long as the care is appropriate to the person's needs.

Iowa's law does not allow serving people who need 24 hour nursing care. Oregon's regulations contain "move out" criteria that allow residents to choose to remain in their living environment despite functional decline. Facilities may ask residents to leave if the resident's behavior poses an imminent danger to self or others, if the facility cannot meet the resident's needs or services are not available, for non-payment or if the resident has a documented pattern of non-compliance with agreements necessary for assisted living.

Utah's facilities may not serve anyone who requires inpatient hospital care or 24 hour continual nursing care that will last more than 15 calendar days or people who cannot evacuate without physical assistance of one person. Written acceptance, retention and transfer policies are required of each facility. Facilities may not accept anyone who is suicidal, assaultive or a danger to self or others, has active tuberculosis or other communicable disease that cannot be adequately treated at the facility or on an outpatient basis or may be transmitted to other residents through **general daily living.**

Physician's statements are required that document the resident's ability to function in the facility and describe the following information: whether the resident's health condition is stable, free from communicable disease, allergies, diets, current

prescribed medications with dose, route, time of administration and assistance required, physical or mental limitations and activity restrictions.

Florida's regulations for "admissions" are very detailed. New residents must:

- be able to perform ADLs with supervision or assistance (but not total assistance);
- be free from signs and symptoms of communicable diseases;
- do not require 24 hour nursing supervision;
- be capable of taking their own medication or may require administration of medication and the facility has licensed staff to provide the service;
- not have bed sores or stage 2, 3, or 4 pressure ulcers;
- be able to participate in social activities;
- be capable of self-preservation;
- not be bedridden;
- be non-violent; and
- cannot require 24 hour mental health care.

Additional criteria affect continued residency. In regular assisted living facilities, people who are bedridden more than 7 days or develop a need for 24 hour supervision may not be retained. In Extended Congregate Care facilities, a higher level of care, residents may not be retained if they are bedridden for more than 14 days. Residents may stay if they develop stage 2 pressure sores but must be relocated for stage 3 and 4 pressure sores. Residents who are medically unstable, become a danger to self or others or experience cognitive decline to prevent simple decision making may not be retained. People who become totally dependent in 4 or more ADLs (exceptions for quadraplegics, paraplegics and victims of muscular dystrophy, multiple sclerosis and other neuro-muscular diseases if the resident is able to communicate their needs and does not require assistance with complex medical problems) may not be retained. State officials are planning to undertake a review of the criteria to evaluate their impact.

Tennessee's new law allows residences to retain for 21 days but not admit anyone requiring intravenous or daily intramuscular injections of feedings, require gastronomy feedings, insertion, sterile irrigation and replacement of catheters, sterile wound care, or treatment of extensive stage 3 or 4 decubitus ulcers or exfoliative dermatitis, or who, after 21 days, require four or more skilled nursing visits per week for any other condition.

In Washington, residents may be required to move when their needs exceed the services provided through the contract with the state agency or the resident

requires a level of nursing care that exceeds what is allowed by the boarding home license.

Although Wyoming expanded their regulations to allow skilled services, they do not allow residents who.wander or need wound care, stage II skin care, are incontinent, need total assistance with bathing and dressing, or continuous assistance with transfer and mobility to be served.

Alabama, Colorado, North Carolina and Rhode Island do not allow anyone needing a nursing home level of care to reside in assisted living or board and care facility.

Other criteria used by states that limit tenancy include bedridden for no more than 14 days, medically unstable, persons requiring two person transfer, incontinence, totally bedfast, or people who are not ambulatory and cannot evacuate in an emergency without assistance.

Negotiated risk

Several states have adopted a process of negotiated risk to respect resident preferences yet respond to preferences that bring risk to the resident or other residents. Washington provides for negotiated risk agreement that is developed as a joint effort between the resident, family members (when appropriate), the **case** manager and facility staff. The document specifies that the agreement's purpose is to "define the services that will be provided to the resident with consideration for preferences of the resident as to how services are to be delivered." The agreement lists needs and preferences for a range of services and specific areas of activity under each service (see table). A separate form is provided to document amendments to the original agreement. Signature space is provided for the resident, family member, facility staff and case manager. If assistance with bathing is needed, the process allows the resident to determine and choose what assistance will be provided, how often and when it will be provided. It allows residents to preserve traditional patterns for eating and preparing meals and engaging in social activities. The negotiated service agreement operationalizes a philosophy that stresses consumer choice, autonomy and independence over a facility determined regimen that includes fixed schedules of activities and tasks that might be more convenient for staff and management of an efficient "facility." It places residents ahead of the staff and administrators and helps turn a "facility" into a home.

The process allows the participants to identify a need and determine with what tasks the residents themselves wish to receive help. For example, if the resident has

difficulty bathing, the resident may prefer help getting to the bathroom and unfastening clothing. Yet a resident may prefer to undress and get into the tub and bath herself/himself even though the staff member and perhaps a family member feel the resident may be placed at risk of falling. The risk is expressed but the final decision to bathe rests with the resident.

Values assume a prominent role in shaping policy in several states. Many states use values language developed in Oregon. The Oregon definition says that "assisted living promotes resident self direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and home-like surroundings." Each facility must have written policies and procedures which incorporate the above principles. Services plans are reviewed for the extent to which the resident has been involved and the resident's choices as well as the principles of assisted living are reflected.

New Jersey defines managed risk as the process of balancing resident choice and independence with the health and safety of the resident and other persons in the facility or program. If a resident's preference or decision places the resident or others at risk or is likely to lead to adverse consequences, such risks or consequences are discussed with the resident and, if the resident agrees, a resident representative. A formal plan to avoid or reduce negative or adverse outcomes is negotiated. The rules provide that choice and independence may need to be limited when the resident's individual choice, preference and/or actions place the resident or others at risk. The managed risk process requires that staff identify the cause for concern, discuss the

Washington Negotiated Service Agreement Areas	
Nursing	Health monitoring, nursing intervention, supplies, services coordination, medication, special requests
Personal service	Toileting, bathing, AM preparation, ambulation, PM preparation, hygiene
Food service	Dietary, eating
Environmental	Safety, housekeeping, laundry
Social/emotional	Family intervention, information/assistance, counseling, orientations, behavior management, socialization
Administration	Business management, transportation
Special needs	

concern with the resident, seek to negotiate a managed risk agreement that minimizes risk and adverse consequences and offers possible alternatives while respecting resident preferences, and document the process of negotiation or lack of agreement and the decisions reached.

Ohio added managed risk provisions to its residential care facility rules in 1996. The rules allow facilities to enter into agreements with residents to share responsibility for making and implementing decisions affecting the scope and quantity of services provided by facility.

Services

The extent and intensity of services generally follows state admission/retention criteria. Services can be provided or arranged that allow residents to remain in a setting. Mutually exclusive resident policies, which prohibit anyone needing a nursing home level of services from being served in board and care, have been replaced by "aging-in-place" provisions. However, drawing the line has been controversial in many states. Opponents of assisted living legislation in Tennessee initially opposed allowing personal care to be provided. In many states, some nursing home operators see assisted living as competition for their "patients" and oppose rules which allow skilled nursing services to be delivered outside the home or nursing home setting.

Most states require an assessment and the development of a plan of care that determines what services will be provided, by whom and when. Residents often have a prominent role in determining what they will receive from the residence and what tasks they will do for themselves. A key factor in assisted living policies is the extent of skilled nursing services. Arizona recognizes three levels of service: hotel, personal care and nursing. Hotel services include meals, linen and personal laundry, housekeeping and social and recreational services. Personal care includes assistance with ADLs, managing functional and behavior problems, assisting with medication and oversight. Nursing services cover observation and assessment, routine nursing tasks, intermittent nursing care and terminal care delivered by hospice providers.

Prior to move in, an interdisciplinary team (manager, staff, RN if nursing services are provided, resident and/or representative and case manager if applicable) conducts an assessment. A plan of care is developed with the resident or their representative that identifies the services needed, the person responsible for providing the service, method and frequency of services, measurable resident goals and the person responsible for assisting the resident in an emergency.

Alaska's regulations also require that tenant contracts spell out the services and

accommodations that will be provided which reflects the diversity of providers and varied availability of service providers in the state. Intermittent nursing services are allowed for residents who do not require 24 hour nursing care and supervision and tasks approved by the Board of Nursing may be delegated to unlicensed staff.

Connecticut allows client teaching, wellness counseling, health promotion and disease prevention, medication administration and skilled services to clients with chronic but stable conditions. Recommendations from a task force in Delaware would allow nursing services that can be planned or scheduled. Draft legislation in Illinois would allow intermittent health services (medication administration, dressing changes, catheter care, therapies). Kentucky's statute does not specifically mention nursing services in a listing of services but includes the phrase "is not limited to" which may allows other services to be added when regulations are prepared.

Florida plans to review the impact of regulations that list the services that may be provided and those that cannot be provided. Facilities may provide limited nursing services (eg., medication administration and supervision of self-administration, applying heat, passive range of motion exercises, ice caps, urine tests, routine dressings that do not require packing or irrigation and others), and intermittent nursing services (eg., change of colostomy bag and related care, catheter care, administration of oxygen, routine care of an amputation or fracture, prophylactic and palliative skin care).

Facilities in Florida may not provide oral or nasopharyngeal suctioning, assistance with tube feeding, monitoring of blood gasses, intermittent positive pressure breathing therapy, intensive rehabilitation services for a stroke or fracture or treatment of surgical incisions which are not clean and free from infection and any treatment requiring 24 hour nursing supervision. Washington has developed a list of skilled services that may and may not be delivered by licensed nurses and unlicensed staff. Nursing services are differentiated by licensure category. RNs or LPNs may provide insertion of catheters, nursing assessments, and glucometer readings. Unlicensed staff may provide the following under supervision of an RN or LPN: stage one skin care, routine ostomy care, enema, catheter care, and wound care. Changes in the nurse practice are pending in the legislature which would allow greater delegation.

Hawaii's draft regulations require facilities to provide nursing assessment and health monitoring; medication administration; services to assist with ADLs; support, intervention and supervision for residents with behavior problems; opportunities for socialization; meals; laundry and housekeeping. Facilities must also provide or arrange for transportation and ancillary services for medically related care (physician, pharmacist, therapy, podiatry, home health and others).

Following its admission/retention criteria, New Jersey's rules allow levels of skilled care that are specifically barred in many states (e.g., stage III or IV pressure sores, ostomy care, 24 hour nursing supervision). Oregon's policy allows a wide range of delegation under which nurses must train unlicensed staff for each resident receiving delegated services. Further, there are no explicit discharge criteria based on service needs.

Legislation in Massachusetts, as in other states, does not allow twenty-four hour nursing services. However, skilled services may only be provided by a certified home health agency on a part time or intermittent basis. Medical conditions requiring services on a periodic, scheduled basis are allowed. In addition, residents may "engage or contract with any licensed health care professional and providers to obtain necessary health care services . . . . to the same extent available to persons residing in private homes." The Massachusetts statute only allows skilled nursing services to be provided by a certified home health agency. As a result, registered nurses, if hired by an assisted living facility, presumably, would not be allowed to deliver skilled care. The initial draft of state regulations did not allow skilled services to be received more than 90 days in a one year period. The attorney general's office reviewed the draft and advised that such limits may conflict with fair housing rules. The 90 day limit was removed.

The Massachusetts statute specifies a minimum level of personal care services that must be provided (bathing, dressing, ambulation) and requires that tenant agreements include the services which will be provided and those which will not be provided. Facilities certified under the law may offer a broader range of personal care services. Alabama's rules mandate personal care for bathing, oral hygiene, hair and nail care but do not require assistance with eating, dressing or toileting.

Levels of care will be defined by regulations under Maryland's new law. New rules governing residential care facilities in Ohio will limit skilled services to 120 days with exceptions for diets, dressing changes and medication administration.

Missouri's rules governing residential care facilities allow advanced personal care services to be provided which include residents with a "catheter or ostomy, require bowel or bladder routines, range of motion exercises, applying prescriptions or ointments and other tasks requiring a highly trained aide."

Iowa's legislation allows health related care which are services provided by a registered nurse, a licensed practical nurse, home care aide and services provided by other licensed professionals as defined by rule. Health related and personal care services can be provided on an intermittent and part time basis, which is defined as

up to 35 hours a week of personal care and health related services on a less than daily basis, or up to 8 hours personal care and health related services provided 7 days a week for temporary periods not exceeding 21 days.

Because of its funding source, New York allows for skilled nursing, home health aide and therapies. Regular Medicaid state plan services have been included in a capitated rate to include the full range of Medicaid long term care services that can be delivered in the home.

In Utah facilities must arrange for necessary medical and dental care although medication administration of prescription drugs is allowed. Maine's revised policy allows skilled services to be provided by a residential care facility or a congregate housing program. Previous policy required skilled services to be provided by a licensed home health agency.

State policy generally specifies the range of allowable services but facilities are not required to provide the full range of services allowed under the law. Facilities are usually authorized to determine which services will be provided. Combined with facility based admission/retention policies, facilities may offer a very light, moderate or heavy level of care. Owners of assisted living facilities who also own nursing homes may develop assisted living as a "feeder" system for their nursing homes and set policies which require residents to "move out" when they develop multiple ADL impairments or require nursing services. Although state regulations frequently explicitly support aging-in-place and resident involvement in care planning decisions, facility specific policies may be developed which limit the potential impact of assisted living to serve residents with higher levels of need.

Reimbursement

States have developed a number of methodologies to set rates for subsidized residents. A unique approach to developing rates has been devised by the state of Washington. The state initially offered contractors a flat per diem rate of $47.37 a day in 1995 consisting of $27.06 for services and $20.31 for room and board. In 1995, the state Aging and Adult Services Administration (AASA) initiated development of a tiered rate structure based on three levels of care needs. AASA sought information from facilities on rate related costs. Working with assisted living facilities, model rates were constructed based on staffing, operations and capital costs. The model assumed an average size facility of 60 units and variations in levels of care.

The process set the rate for nursing costs in King County at $15.16 a day for Level 1 residents, $21.24 for Level 2 residents and $27.82 for Level 3 residents.

Operating costs were $32.28, $32.72 and $33.16 respectively. Capital costs were $8.30, $8.36 and $8.44 respectively. Capital costs varied because of changing assumptions about occupancy rates across levels. In addition, a capital add-on was created for new construction. The rates are increased for new facilities by $4.49 a day in King County. (See table 7).

The methodology sets upper limits that facilities may charge to Medicaid residents. Since Medicaid may only reimburse for services, the room and board portion of the rate is paid by the resident from their social security, pension or SSI benefit. Residents who rely solely on SSI will pay $14.79 a day for room and board. The rates in the table represent total rates that include $14.79 per day for room and board.

Table 7. Washington Rate Structure

	Level I			Level II			Level III		
Component	King county	MSA	Non-MSA	King county	MSA	Non-MSA	King county	MSA	Non-MSA
Nursing	$15.16	$13.44	$12.75	$21.24	$18.72	$17.75	$27.82	$24.47	$23.21
Operations	$32.28	$29.97	$30.24	$32.72	$30.35	$30.65	$33.16	$30.73	$30.78
Capital	$8.30	$7.95	$6.94	$8.36	$8.01	$6.99	$8.44	$8.09	$7.06
Total	$55.74	$51.36	$49.93	$62.32	$57.07	$55.39	$69.41	$63.29	$61.05
Add-on	$4.49	$4.08	$4.34	$4.49	$4.08	$4.34	$4.49	$4.08	$4.34
Total	$60.23	$55.44	$54.26	$66.81	$61.15	$59.72	$73.90	$67.37	$65.38

Under the new system, case managers use a comprehensive assessment to measure the person's level of need. Three sections of the assessment are used to determine the payment level - health status, psychological/social/cognitive status and functional abilities and supports. A three-step process is used to determine the appropriate rate. Six ADLs are weighted and measured: eating, toileting, bathing, ambulation, body care and transfer. Eating, toileting, bathing and ambulation are **assigned a weighted value of 2 while body care and transfer a** given a value of **1.** Residents must be substantially or totally impaired in an ADL to receive a score. Scores of **O-4** are assigned to level 1; 5-10 level 2.

The second step measures speech, sight, hearing, disorientation, memory

impairment, impaired judgement, wandering, disruptive behavior and medication administration. Ten points are assigned to people who have impairments in speech, sight and hearing. Points are assigned based on the number of medications and a weighting which gives higher scores as the number of medications increase. In addition, points are assigned for disorientation (12); memory impairment (16), impaired judgement (17), wandering (15) and disruptive behavior (20).

Step three combines the scores from each section to arrive at a payment level. A computer program reviews the assessment and determines the residents "level" and payment amount. Prior to the new system, a survey of facilities showed that Medicaid residents were "light care" and had relatively lesser ADL impairments. Since its implementation January 1996, very few complaints have been received. While some facilities were worried that their rates might be reduced, most responded to the incentives created and began seeking residents who required higher levels of care.

A Medicaid home and community based services waiver was effective in 1996 that allows New Jersey to serve 1500 residents in assisted living and adult family care settings. New Jersey licenses assisted living as a service provided in a range of settings. Rates have been developed for each of the three settings rather than level of service or other factor. The Medicaid payment includes $300 for state plan services and the remaining amount for waiver services. Newly constructed assisted living residences receive $550 for room and board and $2100 a month for Medicaid services. Comprehensive personal care homes while personal care homes receive $550 for room and board and $1800 a month for services. Assisted living programs (subsidized housing) receive $1500 a month for services. Residents are charged a percentage of their incomes for rent with the remaining amount subsidized by the project. State officials plan to review the methodology and develop a new rate structure.

Table 8. New Jersey Rate Schedule

	Assisted living residences	Assisted living programs	Personal care homes
Room and Board	$550.55	NA	$550.55
Medicaid waiver services	$1800.00	$1200.00	$1500.00
Medicaid state plan services	$300.00	$300.00	$300.00
Total	$2650.55	$1500.00	$2350.55

Oregon uses a five tiered methodology for reimbursing providers based on the type and degree of impairments of residents (See table 9). A room and board payment of $396.70 is paid in addition to the service rate. The levels are assigned based on a service priority score determined through an assessment (see table below). ADLs include eating/nutrition, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder control and behavior.

Table 9. Oregon Service Priority Categories and Payment Rates

Impairment Level	Service Priority	Service	R&B	Total rate
Level V	Service priority A or priority B and dependent in the behavior ADL.	**$1586**	**$396.70**	**$1982.70**
Level IV	Service priority B or priority C with assistance required in the behavior ADL.	$1283	$396.70	$1679.70
Level Ill	Service priority C or priority D with assistance required in the behavior ADL.	$978	$396.70	$1347.70
Level II	Service priority D or priority E with assistance required in the behavior ADL.	$736	$396.70	$1132.70
Level I	Service priority E or F or priority G with assistance required in the behavior ADL.	$553	$396.70	$949.70

Service priority ratings are assigned based on the number and type of impairments in ADLs. Service priority A is assigned to people who are dependent in 3-6 ADLs; priority B -- dependent in l-2 ADLs (see table). About 60% of the Medicaid residents are in Level IV.

Arizona has developed three rate classes based on the needs of the resident. Ohio was also planning to use a service rate structure with five tiers ranging from $200 to $1400 a month that vary based on the number and type of ADL impairments, skilled nursing needs and behavior needs (table 10). The room and board payment was proposed to be $700 a month. The service rate was developed after consultation by the Department of Aging with assisted living providers.

North Dakota uses a rate classification system that is derived from a point system that measures a person's level of service need.

Flat rates are used in Texas and Massachusetts. Rates in Texas, however, do vary by location rather than acuity. Separate service rates are set based on the

Table 10. Ohio Assisted Living Waiver Service Levels (Proposed)	
Service Level	**Minimum Waiver Service Needs**
One	• Assistance with 2 secondary ADLs
Two	• Assist with 1 primary ADL & 1 secondary ADL; or • Level one + medication administration; or • Level one + behavior management; or • Level one + plus unstable medical condition; or, • Level one + daily skilled nursing services not covered under the state Medicaid Plan
Three	• Assist with 4 ADLs (any type); or • Assist with 3 ADLs (including 1 primary ADL) plus medication administration; or • Level two plus behavior management; or • Level two plus unstable medical condition; or • Assist with 3 ADLs (including one primary ADL) plus daily skilled nursing services not covered under the state Medicaid Plan.
Four	• Assist with 5 ADLs (any); or • Assist with 4 ADLs (any) plus medication administration; or • Level three plus behavior management; or • Level three plus unstable medical condition; or . Assist with 4 ADLs (any) plus daily skilled nursing services not covered under the state Medicaid Plan.
Five	• Assist with 5 ADLs plus medication administration AND daily skilled nursing services not covered under the state Medicaid Plan; or . Level four plus behavior management; or • Level four plus unstable medical condition.

settings and the number of occupants. Single occupancy assisted living apartments receive $29.39 a day for services. Residential care units receive $22.96 a day for double occupancy and $18.99 a day for non-apartment, double occupancy models. The SSI rate for room and board is $11.88 a day for all settings.

Massachusetts uses Group Adult Foster Care (GAFC), which is listed as a Medicaid state plan service, to reimburse for services to Medicaid recipients in assisted living. The service payment averages $33.70 per day for Medicaid recipients. The program was developed prior to passage of the assisted living legislation and the program combines two approaches: services in conventional elderly housing projects and purpose built assisted living sites.

Massachusetts, with its high development costs, is the only state that has set a

separate SSI payment for assisted living of $924 a month which is considerably higher than the community standard (the payment for an aged person living alone in the community) and the board and care standard. The increased rate reflects the higher real estate and development costs in the state and provides access for Medicaid recipients to many market rate and mixed income developments. However, legislation creating an assisted living certification program also froze participation until the Medical Assistance Division completed a report showing the projected demand and costs to the state. The report was submitted to the legislature in 1995 and concluded that a higher payment standard would save $2389 per participant for a total savings of $239,800 in FY 95 rising to savings of $4.8 million in FY 99 as the supply of assisted living residences for low income residents increases. In 1996, the legislature requested a plan for controlling costs through the program. A report was expected to be submitted by October 15, 1996. The legislature also reduced the assisted living payment standard to $900 and requires development of a class rate for all providers. A cost based rate is now developed for each program. Once the report is submitted, funds will have to be appropriated to expand participation. Action is not expected until the 1997 legislative session.

The state Medicaid agency prefers to retain coverage of assisted living through the GAFC program as a state plan service rather than as a waiver service. Although spending would be capped under the waiver, the state plan approach allows Medicaid to serve people who are frail but are not eligible to enter a nursing home following a tightening of the level of care criteria.

Several states have modeled their reimbursement rates on their case mix system for paying nursing homes. In New York, the service reimbursement is set at 50% of the resident's Resource Utilization Group (RUG) which would have been paid in a nursing home. The state has created RUG rates for 16 geographic areas of the state. The reimbursement category is determined through a joint assessment by the Assisted Living Program and the designated home health agency or long term home health care program. The assessment and the RUG category are reviewed by the Department of Social Services district office. The residential services (room, board and some personal care) are covered by SSI-which also varies by region. In 1992, the SSI rates were $827 to $857 a month.

Service rates in Minnesota (table 11) are negotiated between the client and the provider with caps based on the client's case mix classification. Service rates under the Alternative Care program, a state funded program for people who do not meet the Medicaid eligibility criteria, cannot exceed the state's share of the average monthly nursing home payment. The client pays for room and board (raw food costs only - meal preparation is covered as a service). The room and board payment standard

under SSI is $589 a month. The cost of services in addition to assisted living services may not exceed 75% of the average nursing home payment for the case mix classification. Under the HCBS waiver, rates for assisted living services are also capped at the state share of the average nursing home payment and the total costs, including skilled nursing and home health aide, cannot exceed 100% of the average cost for the client's case mix classification.

Table 11. Service Rates: Minnesota Case Mix Categories and Average Rate Limits Effective October 1996[1]

Category	Rate		Description
	Elderly	Disabled	
A	**$654**	**$692**	Up to 3 ADL dependencies"'
B	**$737**	**$776**	**3** ADLs + behavior
C	$832	$870	3 ADLs + special nursing care
D	$918	$956	4-6 ADLs
E	$1006	$1045	4-6 ADLs + behavior
F	$1012	$1051	4-6 ADLs + special nursing care
G	$1087	$1125	**7-8** ADLs
H	$1228	$1267	**7-8** ADLs + behavior
I	**$1278**	**$1316**	**7-8 +** needs total or partial help eating (observation for choking, tube or IV feeding and inappropriate behavior)
J	$1355	$1394	7-8 + total help eating (as above) or severe neuro-muscular diagnosis or behavior problems
K	**$1519**	**$1557**	**7-8 +** special nursing

1. Maximum rates vary from these statewide averages by region.
2. ADLs include bathing, dressing, grooming, eating, bed mobility, transferring, walking and toileting.

The statewide maximum rates for elderly recipients ranged from $654 a month to $1519 a month depending upon the case mix classification. Rates in a particular county could be higher or lower than the averages. Rates for participants with physical disabilities ranged from $692 to $1557. About 70% of the participants were assessed as Category A and 96% fall between A and D.

Wisconsin's legislature capped rates at 85% of the statewide average Medicaid nursing home service rate (excluding room and board). It is assumed that counties will have flexibility to negotiate rates with providers within the overall cap set by the state agency.

The SSI payment in North Carolina for room and board is $874 a month (less a personal needs allowance). North Carolina also covers personal care in adult care homes as a state plan service under Medicaid. Homes receive a flat rate for basic personal care. Residents with extensive or total impairments in eating, toileting or both eating and toileting qualify for a higher rate. The basic payment is $8.07 a day which assumes each resident receives one hour of personal care a day. Homes receive higher payments for residents with extensive or total impairments in three specific ADLs: eating, toileting or both. The rate for residents with extensive or total impairments in eating is $16.00 per day, toileting $10.87 per day and impairments in both eating and toileting are reimbursed at $18.80 per day. These three payment levels include the basic rate of $8.07 per day. Eligibility for the added payment is based on an assessment by the adult care home which is then verified by a county case manager.

Table 12. North Carolina Medicaid Rates - monthly

	Basic rate	Eating	Toileting	Eating & toileting
Room and board	$874.00	$874.00	$874.00	$874.00
Personal care	$242.70	$480.00	$326.10	$564.00
Total	$1116.70	$1354	$1200.10	$1438.00

Four states cover services in licensed board and care settings that are sometimes referred to as assisted living. Colorado's Medicaid rules limit room and board charges for Medicaid recipients to $424 a month. Working with provider associations in 1995, the legislature set the service rate based on the average private pay rate in the state. Effective July 1996, the Medicaid rate **for services is $28.82 a** day **($864.60** a month) and includes a 4.3% increase over the 1995 payment level. The rate covers oversight, personal care, homemaker, chore and laundry services. The total monthly rate for an SSI recipient is $1288.60.

In Nevada, personal care services are reimbursed through a Medicaid HCBS waiver in group residential settings if the resident meets the SSI eligibility criteria. Facilities receive a total payment of approximately $1000 a month which includes $781 from SSI for room and board and $9.09 a day ($277.20 a month) for personal care. The state has approximately 35 recipients participating in the waiver. Although the waiver is new, participation has been lower than expected.

The SSI payment, including state supplement, in South Dakota for assisted living facilities is $877 per month. If the Department of Social Services determines that a Medicaid eligible individual also needs medication administration, the facility receives $150 per month through the Medicaid HCBS waiver for a total of $1,027 per month.

Georgia has implemented a small Medicaid HCBS waiver which reimburses two models of personal care homes, the group home serving 1-15 people and the family home serving l-3 people. Group homes are reimbursed at $23.49 per day. Family homes are reimbursed by a provider agency that contracts with the Medicaid agency. Medicaid pays $23.49 to the provider agency which must then pay at least $11.52 to the family home subcontractor. There are 119 group homes participating in the waiver and 32 contracting agencies which may subcontract with more than one family home.

In Missouri, personal care and advanced personal care services are reimbursed as a Medicaid state plan service in residential care facilities. The payment varies by resident based on an assessment and a plan of care completed by a case manager from the Division of Aging. Facilities are reimbursed an hourly rate for the number of hours authorized in the plan of care. The maximum payment is $1700 a month which is tied to the state's Medicaid nursing home costs. The actual number of hours authorized ranges from 5-6 hours to 70 or 80 hours a month. The average number of hours authorized is 25-30 hours a month. The payment rate is $10.07 an hour for personal care aides, $14.61 for advanced personal care aide services and $25.00 an hour for nursing visits. No more than one nursing visit a week can be authorized. Very few residents receive advanced personal care and nursing visits.

The room and board rate is paid through the federal SSI payment and a state "cash grant" or SSI supplement payment. Type I facilities receive a combined payment of $645 a month and Type II facilities receive a combined payment of $752 a month. With an average personal care payment of $302.10, the total payment would equal $947 in Type I facilities and $1054 in Type II facilities.

Montana adopted a payment system based on individual assessment scores. The Medicaid waiver reimburses adult foster care home and personal care facilities between $520 and $1800 a month depending on the level of care needed by

residents. State agency field staff complete the assessment and determine the payment rate. In addition to the room and board component, the basic service payment for residents is $520 a month. Additional payments are calculated based on ADL and other impairments. Points are calculated for each impairment. The functions measured are:. bathing, mobility, toileting, transfer, eating, grooming, medication, dressing, housekeeping, socialization, behavior management, executive cognitive functioning and other. Each function is rated 1, (with aides/difficulty; people who need consistent availability of mechanical assistance or expenditure of undue effort); 2, (with help: requires consistent human assistance to complete the activity but the individual participates actively in the completion of the activity) or 3, (unable: the individual cannot meaningfully contribute to the completion of the task).

Each point equals $33 a month. For example, a resident consistently needing help with toileting would be scored a two and would earn $66 a month for that impairment. Residents with severe impairments, totally dependent in more than three ADLs can receive $44 a month for each point.

The room and board payment under SSI is $564 a month. The total payment (services and room and board) ranges from $1084 to $2363 a month although very few participants have been approved at the highest rate.

Medicaid personal care regulations

Regulations implementing Medicaid changes passed by Congress in 1993 were proposed March 8, 1996 which allow states to cover personal care services in residential settings as an optional state plan service without a waiver. Prior to the change, personal care services were limited to a person's home and had to be ordered by a physician and supervised by a licensed nurse. Home visits by the licensed nurse were required every two months. The new rule provides that personal care is:

- Authorized by a physician in accordance with a plan of treatment or (at the option of the state), otherwise authorized for the individual in accordance with a service plan approved by the state;

- provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and

- furnished in a home, and if the state chooses, in another location.

These changes allow states to develop less medical procedures for authorizing

personal care and setting the qualifications of individuals who may provide care. The rules also drop the requirement for supervision by a registered nurse. While the rules do not allow family members to be providers of personal care, the definition of family member includes a spouse or a parent. While parents could not be paid to provide services to their minor child and spouses could not be reimbursed, adult children can be reimbursed for providing services for their aged parent. However, this section of the rule is applicable to services provided in single family homes or apartments and would not be applied in an assisted living or other group residential setting.

Dementia care

Washington state has included separate requirements for boarding homes providing special dementia care units or services to people with dementia. Boarding home staff must be qualified to serve people with dementia and homes must have sufficient staff to monitor and care for residents, and an alarm or monitoring system to alert staff when a resident leaves the building or enclosed outside area. Boarding homes with dementia units must design floor and wall surfaces to augment orientation and provide access to secured outside space. Units must meet other requirements concerning doors that restrict egress that are alarmed and release automatically during a fire or power failure. Officials are evaluating whether dementia care units are consistent with the state's assisted living mode.

In 1989, the California legislature approved a **3** year demonstration program to test the feasibility of serving people with Alzheimer's Disease in Residential Care Facilities for the Elderly (RCFEs). Seventy five percent of California's residential care facilities have 6 or fewer beds. Prior to the demonstration, RCFEs could serve people with mild or moderate dementia who require protective supervision as long as they can make their needs known and can follow instructions. The pilot was approved to test whether people with more advanced dementia who were required to transfer to nursing facilities could be served in RCFEs. The independent study variables were special staff training, resident activities and the use of either locked or secured (alarmed) perimeters. No facilities were willing to participate as a control group without using the interventions. Staff in both groups received 25 hours of training in residential care, normal aging, Alzheimer's disease, managing problem behaviors, recreational activities, communication, medication use and administration, medications used for disruptive behavior, ADLs, and staff stress and burnout.

Six facilities were selected to participate in the demonstration, three with locked or secured perimeters and three with alarms or other signal devices to alert staff when people were leaving the facility or the grounds.

In April 1994, the California Department of Social Services issued a report and recommendations based on findings from a study of the demonstration program. The report found that both models reduced acting out behavior, diversion of staff time from direct care, and incidents of wandering. The report recommended a separate licensure category for RCFEs specializing in care of people with moderate to severe dementia. However, the report concluded that RCFEs should not be allowed to serve people with serious medical conditions which would require staffing patterns that would significantly raise costs. Examples of conditions which the study found should not be allowed in RCFEs included urinary catheters, colostomies, ileostomies, tracheostomies, tube feeding, contractures, bedsores and intravenous injections. Because of the demands of residents, the report recommended at least two staff be on duty at all times. Other recommendations included training in dementia care, preadmission assessment and reassessments to determine suitability for admission and retention, family meetings, continued standards for the use of "chemical restraints," and increased frequency of monitoring by regulatory staff (quarterly rather than annual).

The report found that the staff-to-resident ratio was more important than the size of the facility and that requirements for specialty staff included in the legislation were not necessary. Beyond requiring one awake staff and two persons at all times, the report suggested that staffing patterns should reflect resident needs for assistance with planned activities and supervision. However, the report did emphasize the need to require adequate outdoor space for resident use. Regulations should specify standards for the amount of space, and other physical characteristics based on the size of the facility.

The report concluded that the use of locked or alarmed perimeters had no impact on medication use and reduction in physical or verbal behaviors (kicking, biting, throwing, screaming, threatening harm) or agitation (pacing, repeated movements, hand wringing, rapid speech). The study was limited by sample problems. Baseline measures showed significant differences among residences in each facility (higher or lower wandering, medication use). The report suggested that increasing the time staff spent with residents and increasing resident social interaction may contribute to a reduction in problem behaviors. While outcomes were similar for both alarmed and secured models, the study found high satisfaction among family members and some reduction in disruptive behaviors.

During 1995, legislation (Chapter 550 of the Acts of 1995) was passed that allows RCFEs that serve people with Alzheimer's Disease to develop secure perimeters. The law allows facilities to install delayed egress devices on exterior doors and perimeter fence gates. Resident supervision devices, wrist bracelets which

activate a visual or auditory alarm when a resident leaves the facility may also be used, Facilities must provide interior and exterior space for residents to wander freely, receive approval from the local fire marshall and conduct quarterly fire drills. Facilities with delayed egress devices must be sprinklered and contain smoke detectors and the devices must deactivate when the sprinkler system or smoke detectors activate. The devices must also be able to be deactivated from a central location and deactivate when a force of 15 pounds is applied for more than two seconds to the panic bar. In addition facilities shall permit residents to leave who continue to indicate such a desire and staff must ensure continued safety. Reports must be submitted when residents wander away from the facility without staff. Delayed egress devices may not substitute for staff.

A voluntary disclosure process has been adopted under which facilities offering special services for people with Alzheimer's Disease disclose information concerning their program. A consumer's guide has been developed which alerts family members to several key questions that should be asked. The areas include the philosophy of the program and how it meets the needs of people with Alzheimer's, the pre-admission assessment process used by the facility, the transition to admission, the care and activities that will be provided, staffing patterns and the special training received by staff, the physical environment and indicators of success used by the facility.

Quality assurance and monitoring

The focus on outcome based performance measures and standards which has gained attention in measuring quality in health care has spread to assisted living. The initiative has gained attention in part as a result of the work of Keren Brown Wilson, President of Assisted Living Concepts, who has developed a paper on this area for the American Association of Retired Persons. Officials in the Washington Aging and Adult Services Division have developed a review guide that operationalizes the principles of assisted living and the concepts of outcome measures.

Washington state is testing an outcome based approach to monitoring quality in assisted living facilities. Prior to monitoring visits, the inspector reviews existing information and prepares a plan for the visit. This includes reviewing the files for complaint history, reviewing DOH inspections reports, checking for information from the long term care ombudsman program and contacting the case manager to determine whether any concerns have been raised by clients and whether any clients have special needs. The reviews include visits with a sample of Medicaid residents.

During the visit, the monitor meets with the residence administrator who informs the residents of the visit. The monitor compares the list of the residents to the list maintained by the department. Staff provide an escorted walk through of the residence to evaluate the home-like quality of the facility, observe activities, interactions between staff and residents, laundry areas, availability of a public telephone, posting of resident's rights as well as the numbers for filing complaints. Based on the size of the facility, a sample of residents is selected for interviews, including at least one resident who receives "limited nursing services" and a resident who does not have a person that can intervene on his/her behalf. The monitor reviews a sample of the negotiated service agreements and notes who was involved in developing the agreement, the extent of the resident's needs, and the agreed upon service plan and ensures that the services required to meet the needs have been delivered. A staff member introduces the monitor to the residents included in the sample. The interviews are held to determine what services were provided, if they were adequate to meet the resident's need and were delivered according to the preferences of the resident.

Direct interviews with residents is the central source of information concerning quality of care. Residents are asked about a range of issues that include the appropriateness of and satisfaction with the service received. Residents are asked to identify what services are being received, whether they are received when and in the manner that is needed, who decided when the services would be delivered, whether any needed services are not being received, and any limitations that need to be addressed.

Residents are asked if they feel as though they are treated with dignity and respect, and to describe their daily routine and who makes decisions about routine activities (getting up and going to bed, eating meals, taking baths) and how well the residence respects the resident's preferences.

Privacy issues are addressed by asking whether the mail is opened, how a person makes personal phone calls, whether service needs have been discussed in front of others. Questions are also asked about support for personal relationships and the maintenance of a home-like environment (do you like the way your room is arranged and decorated? Are your personal possessions safe? Is the housekeeping satisfactory?). Other areas covered include understanding and perception of the rules, adequacy of health care services, and the resident's sense of well-being. Monitors also make observations about the resident's living area and appearance and, if concerns are observed, first checks the person's preferences and choices before a conclusion is reached.

When negative outcomes are observed, the monitor conducts a more focused

and detailed review of the residence in the problem areas to determine whether the facility's administration, policy, procedures or practices are contributing to the outcome. Additional activities include expanding the sample of residents interviewed, more detailed record reviews, and a review of the minutes of the resident council meetings. Monitors will also review the records of residents who have left the residence as well as activity schedules and menus.

Monitors talk with staff and the administrator to discuss observations from the review, and to obtain the provider's perspective on service delivery. Monitors may contact family members or case managers before completing a report. The report covers the physical environment, resident's rights concerning privacy, dignity and choice as well as the awareness of rights, and service delivery.

Under Connecticut's rules, assisted living services agencies (ALSAs) are required to establish a quality assurance committee that consists of a physician, a registered nurse and social worker. The committee meets every four months and reviews the ALSA's policies on program evaluations, assessment and referral criteria, service records, evaluation of client satisfaction, standards of care and professional issues relating to the delivery of services. Program evaluations are also to be conducted by the quality assurance committee. The evaluation examines the extent to which the managed residential community's policies and resources are adequate to meet the needs of residents. The committee is also responsible for reviewing a sample of resident records to determine whether agency policies are followed, services are provided only to residents whose level of care needs can be meet by the ALSA, care is coordinated and appropriate referrals are made when needed. The committee submits an annual report to the ALSA summarizing findings and recommendations. The report and actions taken to implement recommendations are made available to the state Department of Health.

Oregon's rules require providing for ongoing monitoring by the state Senior and Disabled Services Division staff or its designee, usually an area agency on aging. The staff review the service plans of residents for compliance. Written outcome measures covering functional abilities, psycho-social well-being, stability of medical conditions and client/family satisfaction are examined.

Certificate of Need

A few states have certificate of need requirements for assisted living. New York, which reimburses assisted living as a Medicaid service, limits the number of contracted units to 4200 and removes 4200 beds from the nursing home facility bed

need estimates.

New Jersey retains a CoN requirement but provides an expedited review. Connecticut also has a CoN requirement.

States studying assisted living

A number of states have initiated or continue to operate policy groups to develop state policy. The governor of South Carolina has issued a human services plan that includes assisted living and adult family care as one of nine long term care initiatives. A task force consisting of state agencies (Health and Human Services, Aging, Consumer Affairs, the Housing Finance and Development Authority, the residential care facilities association and two nursing home associations) has held meetings. The group plans to issue a report to the full committee in the fall. Legislative action is needed to authorize assisted living.

While there is no formal activity in Michigan, with a recent reorganization of state agencies and the appointment of new commissioners, there is interest in exploring issues related to assisted living.

In New York, a Task Force on Long Term Care Financing issued a report in 1996 that made broad recommendations. A section of the report addressed assisted living and recognized that assisted living has been developed "as an alternative for low income people who would otherwise require nursing facility placement."[7] The report recommends that the program be reformed "to require licensure of assisted living as a specific type of enhanced home care service under the auspices of one State agency." Currently, the program falls under two laws, one licensing adult care facilities and the other licensing home care agencies. The report would allow the residential component to be provided in any type of residential setting, including adult care facilities, that meet building requirements such as the State Uniform Fire Prevention and Building Code. A series of outcome based program requirements would be set for fire safety, nutrition, medication management and case management.

The New York Task Force saw assisted living taking a prominent place in the state's overall long term care strategy and affecting the need for nursing home beds. The report recommended a re-examination of all components of the nursing facility

[7] Findings and Recommendations of the New York Task Force on Long Term Care Financing. p. 31.

bed need methodologies for long term care that reflects projected demographic trends, expected changes in utilization patterns based on increases in managed care penetration, addition of new services options (eg., assisted living) and potential changes in utilization based financing recommendations.

Notes on State Summaries

Each state summary includes the name of the licensure category and the model. States studying the development of new policy are indicated. The models are institutional, housing and services, services and board and care for states without an assisted living category or program. Characteristics of the institutional model include shared rooms, exclusion of residents who meet the nursing home level of care criteria and the inability of the facility to provide or arrange for the delivery of health related or nursing services.

The summaries also include a description of the state's approach to assisted living, the definition, unit requirements, tenant admission and retention policy, services that may be provided, the availability of Medicaid reimbursement for low income residents, medication assistance, staffing requirements, monitoring and a comparison with its board and care model.

The information for each state is based on statutes, regulations, draft legislation, draft regulations and task force reports. Information from states based on draft material is presented to indicate the potential direction of state policy. Final legislation and rules may vary from the source material.

ALABAMA

Category Assisted living **Model** Institutional

General Policy Approach

The state has a licensure category for assisted living but does not differentiate assisted living from board and care. In 1994, the state Commission on Aging organized a series of forums on long term care, held a statewide summit on long term care and formed a Policy Development Council to make recommendations for the reform of the state's long term care system. During the forums and the statewide summit, several nursing home administrators, consumers and others testified to the need for an assisted living program that expanded the range of services that could be provided in assisted living and for changes in the admission policy to allow people who meet the nursing home level of care criteria to be served in assisted living.

A task force was appointed in 1996 which was chaired by the state Health Department. Two meetings were held and a transcript of the meetings was circulated for comments. The transcript and comments from task force members were submitted to the State Health Officer for further action. While generally minor changes were suggested, comments suggested that the range of services be expanded and more attention be paid to fire safety. The task force did not issue a formal report.

The State Health Coordinating Committee has also created a process for reviewing assisted living. While no deadline has been set for issuing a report, two meetings of the task force have been held. The Committee is interested in options for covering assisted living under Medicaid and determining the number of nursing facility residents that could be served in an assisted living setting.

The current regulations license three categories of facilities. Congregate assisted living facilities serve 17 or more adults, group assisted living facilities serve 4-16 adults and family assisted living facilities serve 2-3 adults.

Since 1992 the number of licensed assisted living facilities has grown 21%, from 171 in 1992 to 207 at the end of 1995. The number of beds has increased 30% from, 3,710 in 1992 to 4,840 in 1995.

Definition

Assisted living facility "means a permanent building, portion of a building, or group of buildings (not to include mobile homes and trailers) in which room, board,

meals, laundry, and assistance with personal care and other services provided are for not less than twenty-four hours in any week to a minimum of two ambulatory adults not related by blood or marriage to the owner and/or administrator."

Unit requirements

The regulations do not require separate living and sleeping quarters. Private bedrooms without sitting areas must provide 80 square feet and double rooms 130 square feet. If sitting areas are included, private rooms must be 160 square feet and double rooms 200 square feet. Bath tubs or showers must be available for every 8 beds, and lavatories and toilets for every six beds. Lockable doors are permitted.

Tenant policy

The regulations provide that assisted living facilities may serve persons "who are not in need of hospital or nursing home care." Facilities may not serve anyone with chronic health conditions requiring extensive nursing care and/or daily medication supervision, persons requiring daily professional observation or the exercise of professional judgement by staff. People who need assistance from more than one person to evacuate a building, show severe symptoms of senility, or require restraint or treatment for addiction to alcohol or drugs may not be admitted or retained.

Services

Assisted living facilities must provide personal care for bathing, oral hygiene, hair care and nail care. Facilities may provide for general observation and may arrange or assist residents to obtain medical attention or nursing services when needed. Home health may be provided by a certified agency as long as residents do not require hospital or nursing home care.

Financing

Other than SSI, no public financing is available for assisted living.

Medication

Assistance is limited to reminders, reading container labels to the resident, checking the dosage and opening containers. Registered nurses are allowed to administer medications for residents who do not require acute, continuous or extensive medical or nursing care.

Staffing

The regulations require at least 1 staff member per 6 residents 24 hours a day and personal care staff to meet the needs of residents.

Monitoring

Facilities are monitored through licensure review and periodic inspections by the Board of Health.

Fee

Licensure fees are $200 plus $5 per bed over 10 beds.

Board and care comparison

This model is the equivalent of board and care though the state uses the term “assisted living.” The model also includes adult family care. Residents must be ambulatory and, although home health services may be provided by a certified home health agency, people who qualify for admission to a nursing facility may not be served. Double occupancy is allowed without choice by the resident.

ALASKA

General Policy Approach

In 1994 the Alaska legislature passed a law to encourage the development of assisted living homes to provide a homelike environment for older and persons with a mental or physical disability needing assistance with activities of daily living. The law promotes resident participation in the community, recognizes the resident's right and responsibility to evaluate and make choices concerning the services to be provided. The law provides for licensing assisted living homes for elders, people with dementia, and people with physical, mental or developmental disabilities. The Department of Health and Social Services will license homes for people with mental or developmental disabilities and the Department of Administration will license homes for older people, people with dementia and people with physical disabilities. The agencies are allowed to issue regulations setting additional requirements or standards.

The law was effective January 1, 1995. Regulations were effective in July, 1995. Licenses are required for homes that serve 3 or more residents. Homes serving one or two residents may voluntarily seek a license.

In August 1996, 72 homes with a total of 397 beds had been licensed. This total does not include the state's Pioneer Homes which are six state operated homes that provide supportive services. Of the 72 licensed homes, 85% have 5 or fewer beds; one home has 60 beds which are individual apartments; 3 have 16 beds and two have 8 beds. An estimated 50% of the beds are private rooms.

Holders of residential care facility and adult foster care licenses may convert to an assisted living license. Fifty of the 72 licensed homes converted from a previous license. The regulations set minimal requirements which will be defined in more detail in policies and procedures which will be developed and issued during the first year of the program as experience during the transition is gained. Based on the initial experience, state officials are reviewing the regulations governing the overall enforcement and sanctions procedures to expedite action when warranted; to make the criminal background check procedures consistent with those used by other agencies; and to clarify liability insurance requirements. To expedite reviews and maximize staff capacity, the licensure staff conduct regular orientation sessions to explain the program and its requirements to interested providers. The sessions are held about every six weeks and have reduced the amount of time spent with individual providers or others interested in obtaining a license.

Definition

The law creates "Chapter 33. Assisted Living Homes" to emphasize that assisted living serves as the resident's home. The statute applies to residential facilities serving three or more adults who are not related to the owner of the residence by blood or marriage that provide housing, food service, and provide, obtain or offer to provide assistance with activities of daily living, personal assistance (help with IADLs, obtaining supportive services [recreational, leisure, transportation, social, legal, et.al.], being aware of the resident's whereabouts when traveling in the community, and monitoring activities) or a combination of ADL assistance and personal assistance.

Unit requirements

No requirements are specified for the type of unit. Shared rooms are allowed. Facilities must meet life safety code requirements applicable for buildings its size. Homes for six or more people must meet applicable state and municipal standards for sanitation and environmental protection. In view of the vast expanse and variation within the state, the licensing standards are based on community and neighborhood standards rather than a statewide standard which allows homes to be licensed that are consistent with prevailing local standards.

Tenant policy

The home and each resident must sign a residential service contract that describes the services and accommodations to be provided, rates, the rights, duties and obligations of the resident, and the policies and procedures for terminating the contract. Residents who have exceeded the 45 consecutive day limit for receiving 24 hour skilled nursing (see below) may continue to live at the home if the home and the resident or resident's representative have consulted with the resident's physician, discussed the consequences and risks and a revised plan without 24 hour nursing has been reviewed by a registered nurse. Terminally ill residents may continue to reside in the residence if a physician certifies that the person's needs are being met.

Services

Each resident must have a plan of care developed within 30 **days of move-in** that identifies strengths and weaknesses performing ADLs, physical disabilities and impairments, preferences for roommates, living environment, food, recreation, religious affiliation and other factors. The plan also identifies the ADLs with which the resident needs help, how help will be provided by the home or other agencies, and health

needs and how they will be addressed. The plan must also identify the resident's reasonable wants and how those will be addressed. If health related services are provided or arranged, the evaluation must be done quarterly. If no health services are provided, an annual evaluation is required. Assisted living homes may provide intermittent nursing services to residents who do not require 24 hour care and supervision. Intermittent nursing tasks may be delegated to staff who are not licensed as a nurse for tasks designated by the board of nursing. Twenty four hour skilled care may be provided for not more than 45 consecutive days.

Financing

Room and board and some services are covered by the state's "general relief" program. The payment amounts in the Anchorage area are $30.00 a day for Level I homes, $33.95 for Level II homes and $40.90 in Level III homes.

Services in assisted living homes are funded under the state's Choice Program, a Medicaid HCBS waiver. The Senior Services Division is in process of revising the reimbursement methodology which is currently based on levels of care related to the previous licensure categories. Rates vary by area of the state. In the Anchorage area, Level I homes, formerly adult foster care, provide 24-hour awake staff but do not meet unscheduled needs directly and receive $38.44 a day. Level II homes receive $48.44 a day and have staff capacity to meet unscheduled needs, particularly at night. Level III homes receive $58.44 a day. Homes caring for residents needing extra staff (incontinent, skin care, added supervision, help with medication) can receive a $15 per day add on to the rate. If a resident is also attending adult day care three or more days a week, the rate is reduced by $10 a day. A multiplier is applied to the rates which results in higher payments in rural and frontier areas.

The levels of reimbursement were originally based on the size and staffing level of the three levels of facilities. The rate structure will be revised to reflect residents needs and acuity rather than the size of the facility.

About 25-30% of the Choice participants, 70-75 people, reside in assisted living homes. Case managers from local organizations contract with the Division of Senior Services to conduct assessments, determine eligibility and develop a plan of care for Choice participants who reside in assisted living homes.

Medications

"Home staff persons" may provide medication reminders, reading labels, opening containers, observing a resident while taking medication, checking self-

administered dosage against the label, reassuring the resident that the dosage is correct, and directing/guiding the hand of a resident at the resident's request.

Staffing

Homes must have the type and number of staff needed to operate the home and must develop a staffing plan that is appropriate to provide services required by resident care plans. Staff must pass a criminal background check. Administrators must be 21 years of age or older and have sufficient experience, training or education to fulfill the responsibilities of an administrator.

Monitoring

The Department of Health and Social Services is responsible for investigating applicants, issuing licenses and investigating complaints. The Department may delegate responsibility for investigating and making recommendations for licensing to a state, municipal or private agency. Homes must submit an annual self-monitoring report on forms provided by the department.

Case managers also provide monthly monitoring of residents who are Choice participants.

Fees

Facilities receiving a voluntary license pay a fee of $25, homes serving 3-5 people pay $75 and homes serving six or more residents pay $150.

Alaska Payment Rates - Anchorage Area			
	Level I	**Level II**	**Level III**
Room and board	$900.00	$1018.50	$1299.77
Waiver services	$1153.20	$1453.20	$1753.20
Total	$2053.20	$2471.70	$3052.97
Add on	$450.00	$450.00	$450.00
Total	$2503.20	$2921.70	$3502.97

ARIZONA

Category		Model	
	Adult care homes		Board and care
	Residential care homes		Board and care
	Supervisory care homes		Board and care
	Supportive Residential Living Centers (assisted living)		Housing and services

General approach

The state licenses several settings of care: adult care homes, residential care homes and supervisory care homes. In addition, chapter 163 (1993) authorized a three year supportive residential living center pilot project, which is the same as assisted living, to test the feasibility of developing additional cost effective alternatives to nursing homes for participants in the Arizona Long Term Care Systems (ALTCS). The pilot was implemented in Maricopa County by the Maricopa Managed Care Systems.' Although the statute and regulations do not use the term assisted living, the pilot requires private units, allows nursing home eligible residents to be served, provides nursing services and operates according to the principles of assisted living found in several state programs. Providers submit a statement that demonstrates their knowledge of and commitment to the philosophy of supportive residential living. Participating centers must be certified by the Department of Health Services to deliver of home and community based services. The law views supportive residential living services as in-home services. Participation was capped at 100 “members” until September 30, 1995 and 200 thereafter. As of August 1996, six sites had contracted with MMCS.

In 1996, the legislature approved the statewide expansion of the program and provided funding for 700 ALTCS members and no restrictions on the number of private pay residents. After 1997, there is no limit on the number of members who can be served through Supportive Residential Living.

As required by legislation, Maricopa Managed Care Systems issued a report in December 1995. The report recommended a statewide expansion of the program based on three primary findings: cost effectiveness, high satisfaction level among

[1] Maricopa Managed Care Systems is a county based HMO which contracts with the state Medicaid agency, AHCCCS, to operate the ALTCS system.

participants and the ability to meet resident needs in a less restricting environment.[2] The study found annual savings of $2 million based on the continuous enrollment of 100 participants.

The evaluation collected data on resident satisfaction, number of residents, length of stay, level of care, emergency room utilization, urgent care visits, number of days of hospitalization and cost, average daily cost of supportive residential living, service levels, demographic information, functional information, and medical information. The study identified three areas for further study: building codes, public versus private pay criteria and level of care.

Board and care

Adult care homes means a residential care institution which provides supervisory care, personal care or custodial care services to not more than ten adults who are not related to the manager or owner of the home and who require the assistance of no more than one person to walk or to transfer from a bed, chair or toilet but who are able to self-propel a wheel chair. Custodial services include incontinence care, supervision, personal care, and assistance with self-administration of medications. Residents needing care beyond custodial levels must sign a notarized agreement and receive services from a home health agency. Physicians must also sign a notarized letter approving the added care. No more than three persons may share a room, and rooms must provide 80 square feet for single occupancy and 60 square feet per person for multiple occupancy.

Supervisory care services means accommodation, board and general supervision (protective oversight includes daily awareness of resident functioning and continuous needs and functional level assessment, ability to intervene in a crisis situation), including assistance with self-administration of medications. No more than four people may share a bedroom and one bathroom, toilet and sink is required for every ten residents.

Definition

Supported residential living center means a center that provides or coordinates supportive residential living services on a 24 hour basis in residential units pursuant to

[2] Supportive Residential Living Pilot Project. A Report on the SRL Pilot Status of ALTCS members. Maricopa Managed Care Systems. Phoenix, Arizona. December 1995.

laws 1993, Chapter 163 S 3. (This section authorizes the pilot program and specifies some requirements for participating facilities).

Unit requirements

The residence must meet local building and fire codes based on construction and occupancy. In addition, buildings must meet the Existing or New (as appropriate) Residential Board and Care Occupancies of the Life Safety Code - 1991, NFPA 101 requirements. To be certified, residences submit site plan drawings, floor plans, code information, certificate of occupancy, fire inspection and approval report, building permit and zoning clearance statement.

Each unit must be constructed as a private apartment with living and sleeping space, kitchen area, bathroom and storage areas with a minimum of 220 square feet, excluding the bathroom. Units must have individually keyed locks and resident temperature controls. Kitchen areas must have a sink, refrigerator, cooking appliance that can be disconnected or removed, space for food preparation and storage space for utensils and supplies. Tenants may have pets depending on Center policy.

The evaluation found conflicts between building codes. Life safety codes are required by the Department of Health. Facilities are also required to meet local building ordinances, fire codes and zoning requirements which use the Uniform Building Code rather than Life Safety Codes. It is also not clear how living units are treated by the multiple codes governing apartments, group homes, hotels, nursing facilities or hospitals. A committee was formed within the Maricopa Association of Governments which has worked with the Arizona International Conference of Building Officials to develop a new code for assisted living. The group developed a new code, R-6, as an appendix to the Uniform Building Code.

Tenant policy

Projects cannot serve anyone who needs continuous nursing services, cannot direct their care, needs continuous therapeutic intervention to sustain life and is violent toward self or others. In addition, non-Medicaid (ALTCS) residents cannot require more than one person to assist with ambulation, transfer from bed, chair or toilet or other ADLs, is unable to self-propel a wheelchair or cannot get out of bed more than three hours a day. The passage of HB 2133 requires the same criteria for both ALTCS and private pay residents. The evaluation recommended that the criteria be equalized for ALTCS and private pay residents.

Resident agreements include the terms of occupancy, a statement of the

services provided, services that are available for an additional cost, monthly fees and expenses, deposit and refund policies, termination procedures, copies of the rules and resident rights.

The MMCS evaluation found that 82% of the participants had previously lived in a nursing home. The average resident was 80 years old, female, widowed, needed at least moderate help with 3.5 ADLs and needed assistance with medications.

Services

Services are grouped into three types: hotel services, personal care services and nursing care services. Hotel services include meals, linen and personal laundry, housekeeping and social and recreational services. Personal care includes assistance with ADLs, managing functional and behavior problems, assisting with medication and oversight. Nursing services cover observation and assessment, routine nursing tasks, intermittent nursing care and terminal care delivered by hospice providers.

Prior to move in, an interdisciplinary team (manager, staff, RN if nursing services are provided, resident and/or representative and case manager if applicable) conducts an assessment. A plan of care is developed with the resident or their representative that identifies the services needed, the person responsible for providing the service, method and frequency of services, measurable resident goals and the person responsible for assisting the resident in an emergency.

Financing

One set of rates were established for the providers within guidelines specified in the waiver. Program administrators used rates set for adult foster care, nursing facilities, the Oregon assisted living program and the Arizona HCBS program as guidelines in setting the rates. Administrators also consider the package of services provided and ask each Center to submit a budget. Three classes of rates are negotiated based on the level of care: low, intermediate and high skilled. The rates include room and board which is paid by the resident. The monthly room and board amount is the resident's "alternative share of cost" (spend down) or 85% of the current SSI payment, whichever is greater. For residents who receive SSI, the payment rate is $470 a month of which $403.10 is paid to the residence to cover room and board charges and $66.90 is retained by the resident.

Daily rates: 1995 - 1997		
Class I	**Class II**	**Class III**
$47.33	**$52.88**	**$64.25**

Arizona Rates for 30 dav month			
	Class I	**Class II**	**Class III**
Services	**$1016.80**	**$1183.30**	**$1524.40**
Room & board"'	$403.10	$403.10	$403.10
Total	$ 1 4 1 9 . 9 0	$1586.40	$1927.50

1. Based on residents receiving SSI benefits.

The evaluation found that the average cost of SRL was 58.7% of the cost of a nursing facility in FY 95 - $1567 a month compared to $2669 for nursing facility residents, for a savings of $1102 a month. Ancillary health costs (inpatient, physician, transportation, emergency rooms etc.) were 30% lower for SRL participants than nursing home residents.

Medications

Facilities must have policies and procedures governing the procurement, administration, storing and disposal of medications. Staff may supervise self-administration by opening bottle caps, reading labels, checking the dosage and observing the resident taking the medication. Medications which cannot be self-administered must be administered by an RN or "as otherwise permitted." The phrase as otherwise permitted was included to accommodate any future statutory changes in the state's nurse practice act. Medication organizers can be prepared a month in advance by an RN or family member.

Staffing

The center manager may employ or contract with staff for supportive services, supervision, food service, housekeeping and maintenance, social and activity programs and general supervision. At least one staff must be awake and on-duty. An RN must be available to provide nursing service specified in each plan of care. No staff ratios are included in the regulations and centers are required to have sufficient

personnel available to provide services identified in resident care plans.

Managers must receive 20 hours of continuing education credit each year. Staff are required to receive an orientation from the center and complete a 16 hour training program, approved by the county within 60 days of their employment as well as 20 hours of in-service training a year.

Monitoring

Facilities are monitored by MMCS, the Arizona Health Care Cost Containment System agency, and the Arizona Department of Health Services. Sites are recertified annually by the Department of Health Services during the pilot phase. On a quarterly basis, MMCS monitors resident care, provided technical assistance and conducts meetings of providers to obtain feedback on the program. Annual operating and financial reviews of ALTCS contractors (HMOs) are conducted annually by AHCCCS. The reviews also include case management and provider records and claims data. AHCCCS also reviews a random sample of residents, including SRL residents, to evaluate the appropriateness and quality of care. The review found no unmet needs or quality of care problems.

ARKANSAS

Category Residential care facilities **Model** Board and care

General approach

The state has not developed separate assisted living rules.

Definition

Residential care facility shall be defined as a building or structure which is used or maintained to provide, for pay on a 24 hour basis, a place of residence and board for three or more individuals whose functional capabilities have been impaired, do not require hospital or nursing home care on a daily basis, but could require other assistance with activities of daily living as defined in these regulations. Only self-administered medications can be utilized by these residents.

Unit requirements

Rooms may be shared by as many as four residents. A minimum of 80 square feet is required for single rooms and 60 square feet per resident in shared rooms. A minimum of one toilet/lavatory is required for every six residents and one tub/shower for every ten residents.

Tenant policy

Tenants may not be retained if they require a higher level of medical or nursing services than can be provided by community resources, suffer from mental illness, alcoholism or drug abuse, are not independently mobile, cannot self-administer medication, have gastronomy tubes, intravenous tubes or tracheotomies. Persons with indwelling catheters may be retained if they are self-managed.

Services

Personal care, meals, housekeeping, laundry, social and recreational services are allowed. RCFs may not provide medical or nursing services. Home health services may be provided by a certified home health agency when ordered by a physician.

Staffing

Staffing patterns must be sufficient to meet the needs of residents.

Medication

RCFs may remind residents to take medications and read label instructions.

CALIFORNIA

Category Residential Care Facilities for the Elderly — Model Board and care

General approach

California licenses about 5,000 residential care facilities for the elderly with about 110,000 residents. About 70% of the facilities serve fewer than six residents. These facilities account for between 2530% of all residents. As in other states, nursing facilities are concentrating on providing specialty, sub-acute and rehabilitative care, many through contracts with HMOs. Nursing homes have not expressed interested in converting to assisted living facilities, however, many nursing homes are adding assisted living to free beds for higher need residents and to provide referrals as assisted living residents age.

The state's appropriation legislation for FY 97 directed that the Department of Health conduct a study of state approaches to assisted living. A report and recommnedations is to be filed in January 1997. Prior to passage of the bill, an informal process was initiated that includes the Departments of Health, Social Services, Aging, assisted living providers and legislative staff. Two meetings have been held to discuss the definition of assisted living and where it fits or how it compares to the current residential care facilities for elderly model. The discussion has focused on if assisted living is different, what services should be allowed and whether assisted living should be considered a bundle of services that is provided without regard to the building. Other issues to be addressed include the definition, information needed by consumers, the scope of services to be covered and the needs of tenants that can be met, the place of assisted living in the continuum of care and whether a new licensure category is needed or appropriate.

The 18 member group has discussed financing for low income elders but believes Medicaid waiver financing would lead to a medical model. The Department of Health has concerns about residents meeting the nursing home level of care criteria being served in settings that are not licensed. The Aging community believes there are too many licensure categories already and new ones only serve providers seeking higher levels of reimbursement without really increasing the services provided.

The work group anticipated completing a report in the fall that could become the focus of a hearing by the Senate Subcommittee on Aging and from which legislation would be drafted for submission to the 1997 session.

During 1995, legislation (Chapter 550 of the Acts of 1995) was passed that allows RCFEs that serve people with Alzheimer's Disease to develop secure perimeters. Based on the results of a pilot project, the law allows facilities to install delayed egress devices on exterior doors and perimeter fence gates. Resident supervision devices, wrist bracelets which activate a visual or auditory alarm when a resident leaves the facility may also be used. Facilities must provide interior and exterior space for residents to wander freely, receive approval from the local fire marshall and conduct quarterly fire drills. Facilities with delayed egress devices must be sprinklered and contain smoke detectors and the devices must deactivate when the sprinkler system or smoke detectors activate. The devices must also be able to be deactivated from a central location and deactivate when a force of 15 pounds is applied for more than two seconds to the panic bar. In addition facilities shall permit residents to leave who continue to indicate such a desire and staff must ensure continued safety. Reports must be submitted when residents wander away from the facility without staff. Delayed egress devices may not substitute for staff.

A voluntary disclosure process has been adopted under which facilities offering special services for people with Alzheimer's Disease disclose information concerning their program. A consumer's guide has been developed which alerts family members to several key questions that should be asked. The areas include the philosophy of the program and how it meets the needs of people with Alzheimer's, the pre-admission assessment process used by the facility, the transition to admission, the care and activities that will be provided, staffing patterns and the special training received by staff, the physical environment and indicators of success used by the facility.

Definition

Residential care facility for the elderly means a housing arrangement chosen voluntarily by the resident, or the resident's guardian, conservator or other responsible person; where 75% of the residents are 62 years of age or older, or, if younger, have needs compatible with other residents and where varying levels of care and supervision are provided, as agreed to at time of admission or as determined necessary at subsequent times or reappraisal.

Unit requirements

Occupancy is limited to two residents per bedroom which must be large enough to accommodate easy passage between beds, required furniture and assistant devices such as wheelchairs or walkers. One toilet and sink is required for every six residents and a bath tub or shower for every ten residents.

Tenant policy

Facilities may admit or retain residents who are capable of administering their own medications, receive medical care and treatment outside the facility or from a visiting nurse, residents who need to be reminded to take medications, people with mild dementia, or mild temporary emotional disturbance resulting from personal loss or change in living arrangement. Facilities may not admit or retain anyone with a communicable disease, require 24 hour skilled nursing or intermediate care or are bedridden more than for more than 14 days including residents who are unable to transfer independently to and from bed and are unable to leave the building unassisted in an emergency. The regulations allows residents with health conditions requiring incidental medical services which are specified in the rules to be admitted and retained (eg., intermittent positive pressure breathing, indwelling catheter, management of incontinence, colostomy/ileostomoy, contractures, healing wounds).

Aizheimer's projects Facilities may admit and retain people with Alzheimer's Disease who are not able to respond to verbal instructions to leave a building without assistance provided they have:

- submitted a waiver exception request that includes a plan of operation which specifically addresses the needs of Alzheimer's residents;
- a training plan which ensures that facility staff can meet the needs of residents;
- an activity program and resident assessment and re-assessment procedures;
- procedures to notify physicians when behavior changes;
- a written plan to minimize the use of psychotropic medications; and
- a disaster and mass casualty plan.

Facilities may not admit or retain anyone who requires 24 hour skilled nursing or intermediate care, is bedridden except for temporary illness (14 days) or for recovery from surgery. Bedridden means someone who requires assistance in turning and repositioning in bed and is unable to leave a building unassisted under emergency conditions. Residents who will be bedridden more than 14 days may be retained if the facility submits a physician's statement to the Department of Health stating that the condition is temporary and contains an estimated date upon which the resident will no longer be confined to bed.

The law authorizes three levels of care subject to appropriations. Level I, or basic care level, covers residents who need minimal care and supervision for residents who are able to maintain a higher degree of independence and require minimal care. Level II, non-medical personal care, residents have functional and psychosocial limitations and require frequent assistance with ADLs and active intervention. Level III, health related assistance, residents require frequent assistance with ADLs and occasional skilled service due to chronic health problems. These levels of care have not been implemented.

Services

Services are divided into basic services and care and supervision. Basic services include safe and healthful living accommodations; personal assistance and care; observation and supervision; planned activities; food service; and arrangements for obtaining incidental medical and dental care. Care and supervision covers assistance with ADLs and assumption of varying degrees of responsibility for the safety and well being of residents. The tasks include assistance with dressing, grooming, bathing and other personal hygiene; taking medications; and central storing and distribution of medications.

Medications

Facilities may assist with self-administration of medications and, if staff is authorized by law, administer injections.

Staffing

Sufficient staff must be employed to deliver services required by residents. On the job training or experience is required in the principles of nutrition, food storage and preparation, housekeeping and sanitation standards, skill and knowledge to provide necessary care and supervision, assistance with medications, knowledge to recognize early signs of illness and knowledge of community resources.

Fees

Licensing fees are adjusted by facility size: 1-6 - $100; 7-15 - $150; 16-49 - $200 and 50+ - $250.

COLORADO

Category Personal Care Boarding Homes **Model** Board and care

General approach

Colorado licenses assisted living under personal care boarding home rules. Rules were revised in 1993. The number of licensed facilities has risen from 238 in 1990 to 385 in 1995. Nursing home beds occupied by Medicaid recipients has remained stable over the past ten years at 10,400. State respondents attributed the stable census to the expansion of home and community based programs, including reimbursement of personal care boarding homes. In 1995, the legislature revised the Medicaid rate for alternative care facilities (personal care boarding homes) and participation rose from 70 facilities to over 100. The number of HCBS waiver participants in ACFs rose from 600 to 960 in the first six months of 1996.

While the regulations allow double occupancy and shared bathrooms, the majority of new construction provide private rooms or apartments, including homes that contract with the state to serve Medicaid recipients. The supply of personal care boarding homes is expected to increase. One operator of a small 8 bed personal care boarding home is closing the facility and opening a new one because of consumer demand for private rooms. The licensing agency notes that many nursing facility owners are developing their own personal care boarding homes and few nursing home operators have complained about the level of care offered.

Definition

Personal care boarding home is “A residential facility that makes available to three or more adults not related to the owner of such facility, either directly or indirectly through a provider agreement, room and board and personal services, protective oversight, and social care due to impaired capacity to live independently, but not to the extent that regular 24 hour medical or nursing care is required.”

Units

The rules allow no more than two people to share a room for facilities built after July 1, 1986. Single occupancy rooms must have at least 100 square feet and double occupancy rooms at least 60 square feet per person. Cooking is not allowed in bedrooms and facilities must provide access to a food preparation area for heating or reheating food or making hot beverages subject to “house rules.” Cooking may be allowed in facilities which provide apartments rather than bedrooms.

Facilities must provide at least one bathroom for every six residents.

Tenants

Personal care boarding homes may not admit or retain residents who are:

- consistently, uncontrollably incontinent of bladder unless the resident or staff is able to prevent it from becoming a health hazard;
- incontinent of bowel unless they are capable of self-care;
- totally bedfast;
- require **24** nursing of medical service;
- need restraints; or
- have a communicable disease.

Each facility develops their own admission criteria based on the capacity of the facility. A review Medicaid pre-admission screening assessment forms showed that Medicaid waiver participants 'in ACFs had fewer skilled needs than nursing home residents.

Services

Facilities must provide a physically safe and sanitary environment, room and board, personal services (transportation, assistance with activities of daily living and instrumental activities of daily living, individualized social supervision), protective oversight and social care. Written "board and care plans," which must be reviewed at least annually, are required for each resident and include a list of current prescribed medications (dosage, time and route of administration, whether self-administered or assisted), dietary restrictions, allergies and any physical or mental limitations or activity restrictions.

Nursing and therapies may be received if provided by a home health agency.

Reimbursement

Medicaid rules limit room and board charges for Medicaid recipients to **$424** a month. Working with provider associations in 1995, the legislature set the rate for services based on the average private pay rate in the state. Effective July 1996, the

Medicaid rate for services is $28.82 a day which includes a 4.3% increase over the 1995 payment level. The rate covers oversight, personal care, homemaker, chore and laundry services.

Monthly rates	
Room & board	$424.00
Service	$864.60
Total	$1288.60

Medications

Most larger facilities have hired LPNs to administer or manage medications and ensure that physician's order have been received and recorded. Unlicensed staff may assist with self-administration but they cannot take physicians' orders over the phone.

Staffing

Facilities must employ sufficient staff to ensure provision of services necessary to meet resident needs. Operators must complete a **30** hour training program covering resident rights, assessment skills, environment and fire safety, behavior, nutrition, and meeting the personal, social and emotional care needs of residents.

Monitoring

The regulations require that facilities provide access to the ombudsman program to the facility and residents at reasonable times.

CONNECTICUT

Category	Assisted living services agency Homes for the Aged	Model	Services Board and care

General approach

Assisted living regulations were issued by the Health Department and approved by the Legislative Review Committee in December, 1994. The regulations take a unique approach by allowing "managed residential communities" (MRCs) to offer assisted living services through assisted living services agencies (ALSAs). MRCs may obtain a license to also serve as an ALSA.

Only four assisted living service agencies have been licensed and all are part of continuing care retirement communities. No new facilities have been built. About 115 homes for the aged have been licensed. The supply which declined for several years seems to be increasing as more multi-facility, for-profit companies enter the market and small owner operated homes decline. State officials expect that legislation changing the category from homes for the aged to residential care homes will pass the legislature next year. In addition, the regulations are expected to be revised.

The ALSA regulations focus on the licensing of agencies to provide services rather than the building and services as an entity. MRCs have to notify the health department of their intention to provide assisted living services. The ALSA, either the MRC or another agency, must be licensed by the Department of Public Health and Addiction Services to provide services. The MRC is not licensed by the Department of Public Health and Addiction Services. MRCs must show evidence of compliance with local zoning ordinances and building codes.

Definition

Assisted living services: nursing services and assistance with ADLs provided to clients living within a managed group living environment having supportive services that encourage clients primarily age 55 or older to maintain a maximum level of independence. Routine household services may be provided as assisted living services or by the managed residential community. These services provide an alternative for elderly persons who require some help or aid with ADLs and/or nursing services.

Unit requirements

To qualify as a managed residential community and a setting in which assisted living services may be provided, units are defined as a living environment belonging to a tenant(s) that includes a full bathroom within the unit including water closet, lavatory, tub or shower bathing unit and access to facilities and equipment for the preparation and storage of food.

Tenant policy

Each ALSA agency will develop its own admission criteria but the regulations do not allow the ALSAs to impose unreasonable restrictions and screen out people whose needs may be met by the ALSA. Assisted living services may be provided to residents with chronic and stable health, mental health and cognitive conditions as determined by a physician or health care practitioner.

Services

Services may only be provided by organizations licensed as an assisted living services agency. Nursing services delivered under the regulations and include client teaching, wellness counseling, health promotion and disease prevention, medication administration and delegation of supervision of self-administered medications and provision of care and services to clients whose conditions are chronic and stable.

Registered nurses may also perform quarterly assessments, coordination, orientation, training and supervision of aides.

Financing

The Health and Education Facilities Authority provides loans for the development of assisted living settings. As yet, no specific program has been developed to subsidize services for low income residents.

Medications

The regulations allow for administration of medications by licensed staff. Assisted living aides may supervise the self-administration of medications which includes reminding, verifying, and opening the package.

Staffing

ALSAs must have at least 1 RN and an on-site supervisor 20 hours a week for every 10 or fewer RNs and aides and a full time supervisor for every 20 RNs and aides. A sufficient number of aides must be available to meet residents' needs. All aides must be certified Nurses Aides or Home Health Aides and complete 10 hours of orientation and one hour of in-service training every 2 months.

Twenty-four hour awake staff are not required since the needs will vary among managed residential communities. However, 24 hour staffing could be required if indicated by resident plans of care. An RN must be available on-call 24 hours a day.

Monitoring

ALSAs are required to establish a quality assurance committee that consists of a physician, a registered nurse and social worker. The committee meets every four months and reviews the ALSA's policies on program evaluations, assessment and referral criteria, service records, evaluation of client satisfaction, standards of care and professional issues relating to the delivery of services. Program evaluations are also to be conducted by the quality assurance committee. The evaluation examines the extent to which the managed residential community's policies and resources are adequate to meet the needs of residents. The committee is also responsible for reviewing a sample of resident records to determine whether agency policies were followed, services are provided only to residents whose level of care needs can be meet by the ALSA, care is coordinated and appropriate referrals are made when needed. The committee submits an annual report to the ALSA summarizing findings and recommendations. The report and actions taken to implement recommendations are made available to the state Department of Health.

Fees

Fees are not required for ALSAs.

Board and care

Homes for the aged provide personal care and a maximum of two people to a room. One toilet is required for every six residents per floor and bathing facilities are required for every eight residents. Residents may receive temporary nursing services from a community agency.

DELAWARE

Category Rest residential homes (Planning - assisted living)

Model Board and care
Model Housing and services

General approach

Regulations governing assisted living are being prepared by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) and the Division of Public Health which are expected to be issued in 1997. Funding for approximately 60 Medicaid assisted living slots was initially included in the state's FY 97 budget. However, due to uncertainty about pending federal Medicaid cutbacks, the funds were not included in the final budget. DSAAPD expected to include funds for assisted living in its FY 98 budget submission. Considerable support for funding and regulations is expected from elder advocates and assisted living providers who have testified on behalf of the planning efforts during past hearings.

The developing policy is expected to build on the recommendations from an assisted living advisory committee which was formed in 1995. The task force consisted of representatives from several state agencies (Division of Management Services, Division of Services for Aging and Adults with Physical Disabilities, Division of Public Health, Board of Nursing, Division of Social Services (Medicaid), thirteen providers and two consumers/advocates. The group was created to address the need of elders, adults with physical disabilities and people with spinal cord injuries. The advisory committee found that the current continuum of care does not facilitate aging in place and public funding for residential models of care is limited. Interpretations of current rest residential regulations produce variations in the level of services offered residents.

The group issued a program planning report in September 1995 which proposed creating a new licensure category to "fill the gap between the current Rest Residential and Nursing Home categories." The report recommended that assisted living would overlap with "the higher levels of care in rest residential facilities and the low levels of nursing home care."

The report outlined a program philosophy for assisted living:

> "Assisted living is a major component of a comprehensive community based residential long term care continuum that provides the necessary level of services to a dependent elderly or disabled population in the appropriate environment. The services are provided based on a social model by licensed

agencies and include non-medical 24 hour oversight, food, shelter, and the provision and/or coordination of a range of services that promote the quality of life of the individual. The services are delivered with an emphasis on program, not facility or setting. The assisted living program should be cost effective while providing quality, personalized supportive services."

Assisted living would be developed as a residential long term care option that is licensed as a program in a variety of physical plant settings (eg., clustered apartments, congregate facilities, group or neighborhood home, wing of a nursing facility).

Tenant policy

Admission/retention criteria include people who are: medically eligible for nursing home placement, otherwise require nursing home placement because of lack of a home or other suitable environment, require more care and services that can be provided by adult family care and rest residential providers, do not endanger the health or safety of others, can take action to assure preservation in an emergency, are medically stable and have received sufficient information about assisted living and choose to participate.

Assisted living would not serve people who require supervision 24 hours a day, 7 days a week, are bedridden more than 14 days, can no longer make simple decisions or respond to cuing, have stage 3 or 4 pressure sores, require two person transfer, or are medically unstable.

Services

Services would include personal care and skilled services that can be planned or scheduled. A base service package would be received by all residents that includes availability of 24 hour personal care, 24 hour security, scheduled nursing interventions, 3 meals a day, therapeutic diets, case management, housekeeping, social activities, transportation, personal care planning and medication administration. Clients with head or spinal cord injuries could receive therapies, living skills training and behavioral management services.

Reimbursement

The report proposed developing rates for 3 or 4 levels of care using a sliding fee scale for people with income over 250% of poverty. Market demand rather CoN

restrictions would be used to control supply.

Board and care

Current board and care rules allow up to four people to share to bedroom and require bath/showers and toileting facilities for every four people. Staff may store and distribute medications for self-administration. Facilities may serve people who are normally able to perform activities of daily living.

FLORIDA

Category Assisted living **Model** Multiple settings

General approach

Florida passed initial legislation creating assisted living in 1992. Further legislation was passed in 1995. The bill transferred responsibility for assisted living from the Department of Health and Rehabilitative Services to the Department of Elderly Affairs, renamed adult congregate living facilities and extended congregate care (ECC) as two levels of assisted living and contained new requirements for providing mental health services and staff training. Regulations implementing changes in assisted living became effective June 2, 1996. Facilities serving a higher level of need must obtain an additional license to provide extended congregate care. The law and rules apply a different philosophy and training for ECC facilities than ACLFs.

Florida has very specific admission and retention criteria which were developed to clearly delineate who could be served in assisted living and nursing homes. The rules reflected the opposition of the nursing home industry to a new model of care. The Department of Elderly Affairs planned to conduct a comprehensive review of Extended Congregate Care in the fall of 1996 to examine the admission/retention criteria. State officials indicated that the rules may not always be applied uniformly. Florida has 11 regions and the application of the rules tend to vary depending upon the interpretations taken by surveyors and supervisors. Supervisors in some areas believe people with some conditions should be moved to a nursing home while supervisors in other areas support the concept of ECC and aging in place.

The nursing home industry has changed since the initial rules were written. State officials have noted a statewide trend among nursing homes to serve people with short term rehabilitation needs and as a result, there is less competition or fear of competition from assisted living facilities. While some nursing homes have considered converting to assisted living, none have done so. Occupancy rates average 91% and the state has the third lowest supply of beds/l000 people 65+ in the country. In addition, many nursing homes are developing assisted living facilities as a new line of business. Finally, the assisted living industry itself is more organized and cohesive which has increased their lobbying effectiveness.

In November, 1995 there were approximately 5400 units of assisted living in 1900 facilities. About 120 of the 1900 facilities also hold a license to provide ECC services. An additional 600 units have been developed between November 1995 and June 1996.

Changes in state policy are seen as supporting expansion of assisted living. The recently passed state budget includes funding to expand the Medicaid assisted living waiver from 225 to 337 slots. In addition, $11 million has been appropriated to implement a long term care pilot project. About half the funding is expected to be spent on Medicaid recipients who are in assisted living facilities.

Definition

"Assisted living facility means any building or buildings, section of a building or distinct part of a building, residence, private home, boarding home, home for the aged or other place, whether operated for profit or not, which undertakes to provide through its ownership or management, for a period exceeding 24 hours, housing, food service, and one or more personal services for four or more adults, not related to the owner or administrator by blood or marriage, who require such services; or to provide extended congregate care, limited nursing services, or limited mental health services, when specifically licensed to so pursuant to s. 400.407, unless the facility is licensed as an adult family care home."

"Extended congregate care means acts beyond those authorized in subsection 16 that may be performed pursuant to chapter 464 by persons licensed thereunder while carrying out their professional duties; and other supportive service which may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency in a facility licensed under this part." This definition creates a higher level of care in assisted living which requires a separate license.

Facilities with an ECC license must develop policies with allow residents to age in place and which maximize the independence, dignity, choice and decision making; specify the personal and supportive services that will be provided; specify the nursing services to be provided and describe the procedures to ensure that unscheduled service needs are met.

Unit requirements

Facilities licensed to provide extended congregate care must provide private rooms or apartments, or semi-private room or apartment shared with a roommate of choice, with a lockable entry door. Facilities that offer rooms rather than apartments must have bathrooms shared by no more than three residents.

Facilities that do not have the ECC license may offer shared rooms, maximum 4 per room, a bathroom for every 6 residents and bathing facilities for every 8

residents.

To receive services under the Medicaid waiver, tenants must be 60 years of age or older and meet one of the following criteria:

- Require assistance with four or more ADLs or three ADLs plus supervision or administration of medications;
- Require total help with one or more ADLs;
- Have a diagnosis of Alzheimer's Disease or another type of dementia and require assistance with two or more ADLs;
- Have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard ACLF;
- Are Medicaid eligible, awaiting discharge from a nursing home but cannot return to a private residence because of a need for supervision, personal care, periodic nursing services or a combination of the three.

Tenant policy

Admission The regulations for "admissions" are very detailed. New residents must:

- be able to perform ADLs with supervision or assistance (but not total assistance);
- be free signs and symptoms of communicable diseases;
- not require 24 hour nursing supervision;
- be capable of taking their own medication or may require administration of medication and the facility has licensed staff to provide the service;
- not have bed sores or stage 2, 3, or 4 pressure ulcers;
- be able to participate in social activities;
- be capable of self-preservation;
- not be bedridden;
- non-violent; and
- cannot require 24 hour mental health care.

Continued residency Additional criteria affect continued residency. In regular assisted living facilities, people who are bedridden more than 7 days or develop a need for 24 hour supervision may not be retained.

In ECC facilities, residents may not be retained if they are bedridden for more than 14 days. Residents may stay if they develop stage 2 pressure sores but must be relocated for stage 3 and 4 pressure sores. Residents who are medically unstable, become a danger to self or others or experience cognitive decline to prevent simple decision making may not be retained. People who became totally dependent in 4 or more ADLs (exceptions for quadraplegics, paraplegics and victims of muscular dystrophy, multiple sclerosis and other neuro-muscular diseases if the resident is able to communicate their needs and does not require assistance with complex medical problems) may not be retained.

Terminally ill residents may continue in a facility if a licensed hospice agency coordinates services, an interdisciplinary care plan is developed and all parties agree to the continued residency.

Services

Two levels of licensure are available. The first level allows facilities to provide personal care and administration of medications.

Facilities with an ECC license may provide a higher level of service including total care with up to 3 ADLs and limited nursing services. ECC facilities must describe the personal, supportive and nursing services to be made available. Facilities may provide limited nursing services (eg., medication administration and supervision of self-administration, applying heat, passive range of motion exercises, ice packs, urine tests, routine dressings that do not require packing or irrigation and others), intermittent nursing services (eg., routine change of colostomy bag and related care, catheter care, administration of oxygen, routine care of an amputation or fracture, prophylactic and palliative skin care).

Other supportive services that may be provided include counseling, emotional support, networking, assistance securing social and leisure services, shopping, escort, companionship, family support, information and referral, transportation assistance developing and implementing self-directed activities. In addition, facilities provide ongoing medical and social evaluation, dietary management, and medication administration.

ECC facilities must make available nursing diagnosis or observation and evaluation of physical conditions, ongoing medical and social evaluation to determine when the person's conditions cannot be met within the facility, control of occurrence of infections, promotion of normal elimination patterns through diet and exercise, routine measurement and recording of vital functions, dietary management, administration of

medications and treatment, preventive regimens for residents liable to develop pressure sores, provide or arrange for rehabilitation services, transportation or escort services for health related services.

ECC facilities **may not** provide oral or nasopharyngeal suctioning, assistance with tube feeding, monitoring of blood gasses, intermittent positive pressure breathing therapy, intensive rehabilitation services for a stroke or fracture or treatment of surgical incisions which are not clean and free from infection and any treatment requiring 24 hour nursing supervision.

The Medicaid waiver includes the following services for recipients in ECC settings: personal care, homemaker, attendant and companion, medication administration and oversight, therapeutic social and recreational programming, physical, occupational and speech therapy, intermittent nursing services, specialized medical supplies, specialized approaches for behavior management for people with dementia, emergency call systems and case management.

Financing

A total of **$2.3** million was approved in 1994 for 220 Medicaid Home and Community Based Services Waiver slots as a pilot program. The SSI benefit is $586 a month. The program reimburses providers $750 a month for services for a total payment of $1336 less the personal needs allowance. An evaluation of the program will be done to examine levels of need and developed a tiered rating system as appropriate.

To be eligible for the program, recipients must be an SSI recipient, have income under 300% of the federal SSI benefit or, for aged and disabled applicants, have income under 90% of the federal poverty level.

Medications

Medications may be administered by staff within the scope of their license.

Staffing

The regulations specify minimum staffing hours per week that vary with the number of residents. Administrators must be over 18 years of age, have at least a high school diploma or equivalency, comply with training requirements and complete a background check. Staff must be employed that are able to assure the safety and proper care of residents and implement the evacuation and emergency management

plan.

Administrators must complete a core training program and continuing education covering state laws and rules, identifying and reporting abuse and neglect, meeting the special needs of elderly persons and persons with mental illness, nutrition and food services, providing assistance with medications, fire safety and first aid. Staff providing personal care staff receive personal hygiene training, 3 hours of training in personal care tasks and 2 hours of training in self-administration of medications.

ECC administrators and care supervisors must have at least 2 years of managerial, nursing, social work, therapeutic recreation or counseling experience. A BS degree may substitute for one year of experience. In addition to the regular training requirements, direct care staff must complete 12 hours in ECC concepts and administrators and supervisors must have 6 hours of continuing education a year in the physical, social or psychological needs of frail elders, persons with Alzheimer's disease and how to meet those needs. Facilities providing ECC services must have staff to meet the care needs of residents and they must employ or contract with an RN, LPN or nurse practitioner. The ratio of staff FTEs to the number of residents does not apply.

Monitoring

Registered nurses must visit ECC facilities three times a year to monitor residents and to determine if the facility is in compliance with relevant rules.

Fees

The base biennial fee is $240 per license plus $30 per resident. Facilities providing ECC services pay an additional fee of $400.

GEORGIA

Category Personal Care Homes **Model** Board and care

General approach

A Medicaid waiver provides reimbursement for group homes (<15). A work group has recommended that the size limits be raised to homes with 24 units. A lower limit was set in order to provide more home-like settings.

Definition

"Any dwelling, whether operated for profit or not, which undertakes through its ownership or management to provide or arrange for the provision of housing, food services, and one or more personal services for two or more adults who are not related to the owner or administrator by blood or marriage."

There are 1,825 facilities with about 16,000 units in Georgia.

Unit requirements

Bedrooms must have at least 80 square feet of usable floor space per resident. There may be no more than four residents per bedroom. Spouses may be permitted, but not required to share a bedroom. Both the occupant and the administrator or on-site manager must be provided with keys for rooms with lockable doors.

Tenant policy

Personal Care Homes serve people 18 and older who meet the personal care definition of "ambulatory" - "a resident who has the ability to move from place to place by walking, either unaided or aided by prosthesis, brace, cane, crutches, walker or hand rails, or by propelling in a wheelchair; who can respond to an emergency condition ... and escape with minimal human assistance. ..." Personal Care Homes cannot admit or retain persons who need physical or chemical restraints, isolation, or confinement for behavioral control. Residents may not be bed-bound or require continuous medical or nursing care and treatment.

If short term medical, nursing, health or supportive services are necessary, the resident (or representative) is responsible for purchasing them from licensed providers that are managed independently of the home. The home may assist in the

arrangement for such services, but not the provision of those services. Applicants requiring continuous medical or nursing services shall not be admitted or retained.

Services

Room, meals, and personal services which include but are not limited to individual assistance with or supervision of self-administered medication, assistance with ambulation and transfer, and essential activities of daily living.

Financing

A small Medicaid HCBS waiver reimburses two models of personal care homes, group homes serving 7-l 5 people and the family homes serving l-6 people. Group homes are reimbursed at $23.49 per day. The SSI payment for room and board is $470 less a personal needs allowance of $82 a month. Family homes are reimbursed by a provider agency that contracts with the Medicaid agency. Medicaid pays $23.49 to the provider agency which must then pay at least $11.52 to the family home subcontractor. There are 119 group homes participating in the waiver and 32 contracting agencies which may subcontract with more than one family home.

Staffing

At least one administrator, on-site manager, or a responsible staff person must be on the premises 24 hours per day. The minimum on-site staff to resident ratio is one staff person per fifteen residents during waking hours and one staff person per 25 residents during non-waking hours.

The administrator, on-site manager, and all other responsible staff persons must be at least 21. All persons, including the administrator or on-site manager, who offer direct care to the resident must complete 16 hours of continuing education each year, including courses in working with residents with Alzheimer's disease or other cognitive impairments; working with people with mental retardation, developmental disabilities, or mental illness; social and recreational activities, legal issues; physical maintenance and fire safety; housekeeping; or other topics.

All employees must receive work-related training acceptable to the Department within the first 60 days of employment. This training must include: current certification in emergency first aid, except where the staff person is a currently licensed health care professional; current certification in CPR; emergency evacuation procedures; medical and social needs and characteristics of the resident population; residents' rights; and a copy of the Long Term Care Abuse Reporting Act.

Monitoring

The Office of Regulatory Services investigates complaints and the Division of Public Health conducts an annual inspection. Inspections may be conducted on an announced and unannounced basis.

HAWAII

Category Assisted living

Model New housing and services

General Approach

In 1994, a multi-member task force was created by House Concurrent Resolution 377 to make recommendations concerning assisted living and to explore the use of Medicaid waivers to support low income residents in assisted living. The report was issued in December 1994 and recommended that the Department of Health be authorized to develop regulations to establish an assisted living program. Members of the task force made site visits to facilities in Oregon and Washington. Legislation authorizing the development of assisted living regulations was passed in April, 1995. Draft regulations were issued for comment in November 1996.

Definition

Assisted living is defined as a "philosophy of caring that encourages and supports individuals to live independently and receive services and assistance to maintain independence. All individuals have a right to live independently with respect of their privacy and dignity, free from restraints."

Assisted living facility is defined as "a combination of housing, health care services, and personalized supportive services designed to respond to individual needs, to promote choice, responsibility, independence, privacy, dignity and individuality. This facility is a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The environment of an assisted living facility is one in which meals are provided, staff are available on a 24-hour basis and services are based on the individual needs of each resident. Each resident, family members and others work together with facility staff to assess what is needed to support the resident in his/her greatest capacity for living independently. The facility is designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.

Unit

The draft rules require apartment units with a bathroom, refrigerator and cooking capacity, including a sink and a minimum of 220 square feet, not including the bathroom (sink, shower and toilet). The cooking capacity shall be removed or disconnected depending on the needs of the resident. Other requirements include

wiring for phone and television, a private accessible mail box and a call system monitored 24 hours by staff.

Tenant policy

Each facility must develop admission policies and procedures which support the principles of dignity and choice. The policies include a listing of services available, the base rates, services included in the base rates, services not provided but which may be coordinated and a service plan and contract. Facilities must also develop discharge policies and procedures which allow 14 days notice for behavior, needs that exceed the facility's ability to meet or the resident's established pattern of non-compliance. The rules do not specify

Services

Facilities shall provide awake, 24 hour on site staff, three dietitian approved meals a day, laundry services, opportunities for individual and group socialization, services to assist with ADLs, nursing assessment and health monitoring, housekeeping, medication administration and services for residents with behavior problems (staff support, intervention and supervision). Facilities must also arrange or provide transportation, ancillary services for medically related care (physician, pharmacist, therapy, podiatry), barber beauty care, hospice, home health and other services.

Service agreements are developed using negotiated risk principles.

Financing

The report suggested that land policies should be reviewed and modification of zoning requirements made to allow existing housing stock to be used. State loans and bonds would be made available to at favorable interest rates to stimulate development. The report recommended consideration of providing a higher level of service in residential care facilities as a means of maximizing existing buildings to meet new needs. A resolution passed the legislature directing the Medicaid Agency to study the feasibility of using a Medicaid Home and Community Based Services Waiver to finance services.

Medication

The draft rules allow assistance with self-administration and administration of medication as allowed under the nurse practice act.

Staffing

Facilities must have licensed nursing staff available seven days a week to meet care management and monitoring needs of residents. The administrator/ director must have two years experience in the health and social services field plus relevant experience in gerontology and show evidence of having completed an assisted living facility administrator's course acceptable to the Department. The facility must have written policies and procedures which incorporate the principles of individuality, independence, dignity, privacy, choice and home-like environment. An in-service education program is required which provides an orientation for new employees and ongoing in-service training (minimum of six hours).

Monitoring

The rules require biannual inspection and license renewal.

Fees

Fees will be established by the Department of Health.

Board and care

Adult residential care homes are licensed in two groups, Type I for five or less and Type II for six or more residents. Type I homes may serve two people in a bedroom and up to four people may share a bedroom in Type II homes. Single rooms must have 90 square feet and multiple occupancy rooms 70 square feet per occupant. One toilet is required for every eight residents, one shower for every 14 residents and one lavatory for every ten residents. Homes may not admit or retain anyone needing the level of care provided in a nursing home.

IDAHO

Category Residential Care Facilities **Model** Board and care

General Approach

In 1996, the legislature passed HB 742 which made changes in the state's residential care facility rules, Medicaid is considering adding assisted living as a covered services under the HCBS waiver.

In 1995, a concept paper was prepared by the Idaho Residential Care Council that outlined a policy for assisted living. The draft paper stated that assisted living serves people who need assistance with ADLs but not skilled nursing care. Assisted living promotes independence and dignity for each resident in a home like atmosphere rather than a medical atmosphere.

The paper envisioned assisted living as providing care that is less intensive than nursing home care and more services than are available in independent housing. Licensing would be done in a manner that does not remove independence and choice from the resident.

There are 175 facilities and 3,500 beds in Idaho.

Definition

Residential care facility: "One or more buildings constituting a facility or residence, however named, operated on either a profit or nonprofit basis, for the purpose of providing twenty-four hour nonmedical care for three or more elderly adults, not related to the owner, who need personal care or assistance and supervision essential for sustaining activities of daily living or for the protection of the individual."

Specialized care units/facilities for Alzheimer's/dementia residents "are specifically designed, dedicated, and operated to provide the elderly individual with chronic confusion, or dementing illness, or both, with the maximum potential to reside in an unrestrictive environment through the provision of a supervised life-style which is safe, secure, structured but flexible, stress free and encourages physical activity through a well developed activity and recreational program. The program constantly strives to enable residents to maintain the highest practicable physical, mental or psychosocial well-being."

Unit requirements

Facilities licensed before July 1, 1991 must not have more than four residents per bedroom, and new facilities or conversions licensed after July 1, 1992 must not have more than two residents in each bedroom. Facilities that have been continuously licensed since before May 9, 1977 must have 75 square feet of floor space per single bed rooms and 60 square feet per resident in multi-bed rooms. Facilities licensed after May 9, 1977 must have 100 square feet of floor space per single bed rooms and 80 square feet per resident in multi-bed rooms. There must be at least one toilet for every six persons, residents or employees, and at least one tub or shower for every eight persons, residents or employees.

Tenant policy

Residents, by reason of age or infirmity, require supervision and personal assistance with one or more of the following services: protection, assistance with decision-making and activities of daily living, and direction toward self-care skills. There are three levels of care to which a resident may be assigned: minimal assistance, moderate assistance, and maximum assistance.

Minimal assistance (Level I) means the resident requires room, board, and supervision, and requires only verbal prompting to function independently in ADLs, is independently mobile, is capable of self preservation, and does not require medication management or supervision. Moderate assistance (Level II) means the resident requires room, board, and supervision, and requires both verbal prompting and some physical assistance with ADLS, mobility (such as transferring, climbing stairs and walking), self preservation, medication management, and behavior management. Maximum assistance (Level Ill) means that the resident requires room, board, supervision, and requires staff up and awake on a 24-hour basis and may require extensive hands on assistance with ADLs, non-medical personal assistance needs, mobility such that the person may be immobile without assistance, self preservation, medications such that the person needs extensive assistance with the self-administration of medications, or extensive behavior management for antisocial or aggressive behavior.

Residents may not be admitted or retained if they require ongoing skilled nursing, intermediate care or care not within the legally licensed authority of the facility for the elderly. Residents may not be admitted or retained who are unable to feed themselves, who are bedfast, who are in need of nursing judgment for an ongoing unstable health condition, who have decubitus ulcers or open wounds, who need the ongoing technical or professional personnel to appropriately evaluate, plan and deliver

resident care, who are beyond the level of fire safety provided by the facility, who have physical, emotional, or social needs that are not homogenous with other residents in the home, or who are violent or a danger to themselves or others. Residents who need ongoing 24 hour nursing care must be discharged. Residents who need 24 hour care for a short time for an acute condition may be retained.

Residents of specialized care units for Alzheimer's disease must be evaluated by their primary care physician for the appropriateness of placement into the unlocked specialized care unit/facility prior to admission. No resident shall be admitted to these units without a diagnosis of Alzheimer's disease or related disorder. Residents must be at a stage in their disease such that only periodic professional observation and evaluation is required. Residents in these units must be re-evaluated quarterly. No resident shall be admitted who requires physical or chemical restraints.

Services

Services include assistance with activities of daily living, arrangements for medical and dental services, provisions for trips to social functions, recreational activities, maintenance of self-help skills, special diets, arrangement for payments and medication management. A licensed nurse must visit the facility at least once a month to conduct a nursing assessment of each resident's response to medications and to assure that the medication orders are current. The nurse also assesses the health status of each resident and makes recommendations to the administrator regarding any needs.

Services in specialized care units for Alzheimer's disease include habilitation services, activity program and behavior management according to the individualized plan of care.

HB 742 requires use of a uniform assessment and a negotiated service agreement with residents. New rules will address qualifications of assessors, state responsibilities for public clients, time frames for completing assessments and the information to be included. The negotiated service agreement is based on the assessment and provides for coordination of services and guidance of staff. Residents shall be given the choice and control of how and what services the facility, or external vendor, will provide to the extent the resident can make choices.

Financing

Currently, residential care homes are reimbursed privately and through a state fund. The highest reimbursement rate from the state fund is $800, and the private pay

rate is generally $900 to $1200. The SSI rate in Idaho in about $500.

Staffing

Under HB 742, requirements that administrators be 21 years of age and successfully complete a basic training and participate in ongoing training were dropped. Administrators must have a valid residential care administrator's license. Personnel must be given an orientation to the facility and participate in a continuing training program developed by the facility. Staff who provide personal assistance must have a minimum of 6 hours of job-related preset-vice orientation training. These employees must also have at least 12 hours of job-related continuing training/in-service training per year. All employees must participate in fire and safety training upon employment and at intervals of not more than six months thereafter.

Staff ratios vary on the level of care of the residents in the facility. Facilities retaining only Level I residents must have a ratio of one to thirty residents, with one direct care staff person to assist residents at all times during waking hours. One person must be immediately available at the facility during sleeping hours. A second person must be on call within five minutes response time to assist in caring for residents in an emergency. Facilities retaining Level I and Level II clients have staff ratios of one to twenty residents with one direct care staff person to assist residents at all times. One staff person must be awake during the residents' sleeping hours if the facility has thirty or more residents. Facilities retaining Level III clients must have staff ratios of one to twelve residents, with one staff person to assist residents at all times during waking hours. There must be a minimum of one staff person up and awake during the residents' sleeping hours in the same building, with one person on call. For all levels of care, additional staffing may be required based on the needs of the residents.

Staff in specialized care units for Alzheimer's/dementia residents must complete an orientation/continuing training program that includes information on Alzheimer's and dementia, symptoms and behaviors of memory impaired people, communication with memory impaired people, resident's adjustment, inappropriate and problem behavior of residents and appropriate staff response, activities of daily living for special care unit residents, and stress reduction for special care unit staff and residents. Staff must have at least six additional hours of orientation training, and four hours of the required twelve hours **per year of continuing education must be** in the provision of services to persons with Alzheimer's disease.

Monitoring

With the exception of the initial surveys for licensure, all inspections and investigations shall be made unannounced and without prior notice. Inspections are conducted at least annually. Inspections entail reviews of the quality of care and services delivery, resident records, and other items relating to the running of the facility. If deficiencies are found, then plans of correction are made and follow-up surveys are conducted to determine if corrections have been made. Complaints against the facility are investigated by the licensing agency. A complainant's name or identifying characteristics may not be made public unless "the complainant consents in writing to the disclosure; the investigation results in a judicial proceeding and disclosure is ordered by the court; or the disclosure is essential to the investigation. The complainant shall be given the opportunity to withdraw the complaint before disclosure."

Inspections of specialized care units for Alzheimer's disease are conducted by the licensing agency with participation from the Regional Department staff who have program knowledge of and experience with the type of residents to be served and the proposed program offered by the facility. Facilities that are specialized or have specialized care units must submit a synopsis of the program of care to be offered by the unit/facility.

ILLINOIS

Category Assisted living (developing)
Shelter care facilities

Model Services
Model Board and care

General Approach

In 1996 legislative session a bill which would have created a new licensure category for assisted living was vigorously opposed by some nursing home industry groups, The legislature did approve a series of demonstration projects related to assisted living but did not create a separate licensure category.

A "supportive living" model is a Medicaid model being developed by the Department of Public Aid. It will target lighter need nursing facility residents who are unable to remain in their homes or totally independent settings but do not need 24-hour nursing care. The Medicaid model will operate in converted nursing home units or free standing buildings and integrate housing, health, personal care and supportive services in home-like residential settings. The program will be consistent with the definition of assisted living used by the federal 1915 c Medicaid **Home and Community Based Services Waiver program.**

The supportive living model is being developed with the assistance of advisory groups composed of members of the nursing home industry, advocates, consumers and the aging network. Rules and a request for proposals for potential supportive living providers are being developed. The Department of Public Aid plans to begin this program in FY 98 and it will last for five years.

A transitional assistance initiative currently being implemented by the Department of Public Aid, Aging, and Rehabilitation Services offers residential options to nursing home residents who no longer need the nursing level of care or are considered "light need." Through this deinstitutionalization initiative in five counties, discharge plans would be developed to relocate these residents into their homes or independent living settings. If successful, the initiative could ultimately relocate clients **to** the supportive or assisted living models currently being developed.

The Department on Aging will develop a second demonstration, based on a services model. Two assisted living sites, one **in a rural area and one** in a suburban area, will use residential settings to provide assisted living services. The services will be reimbursed as home care services through the Medicaid Home and Community Based Services Waiver or state funds. Two sites have been identified and the buildings are under construction. All residents of the buildings will presumably receive

services. A third site involving a nursing home may be implemented if any nursing homes are interested in applying. The projects may serve a total of no more than 360 people. The authorizing statute allows the programs to serve people with short or long term needs as a means of relieving family caregivers. Projects may offer directly or through contracts services that preclude admission to a nursing home. Sites that continue to be in compliance with the demonstration project rules will be eligible for annual renewals "until an assisted living or similar licensure model is established by legislation."

The Illinois Life Services Network (formerly known as the Illinois Association of Homes and Services for the Aging) organized a statewide Summit and an ongoing task force to develop an assisted living model. The group recommended a registration procedure administered by the Department on Aging. The procedure would require evidence of compliance with rules governing quality assurance that would be developed by the Department on Aging and an Assisted Living Advisory Commission. In addition, the process requires documentation of liability insurance, the number and type of units, the maximum census, residential standards and a copy of the contract to be signed with residents. Legislation developed by the task force will be resubmitted for consideration during the 1997 session.

Current licensure rules require that any board and care facility serving 3 or more residents who receive assistance with care from the facility must be licensed as a nursing home. Facilities contract with outside agencies to deliver services without violating the licensure standards. Organizations that own board and care and home care agencies are not allowed to use their own agencies to deliver care.

Illinois has a high supply of nursing homes. Occupancy rates are between 80-82% and a high percentage of residents have minimal impairments.

Definition

The Medicaid Advisory Committee has recommended the following definition to the Department of Public Aid:

> Assisted living combines housing, personal and health related services in response to the individual needs of those who need help in activities of daily living and instrumental activities of daily living. Supportive services are available 24 hours per day, if needed, to meet scheduled and unscheduled needs, in a way that promotes self-direction and participation in decisions that emphasize independence, individuality, privacy, and dignity in a residential surrounding.

The definition proposed by the Life Services Network of Illinois added the words "and intermittent health related" services after supportive services in the second sentence.

Units

In the Department on Aging pilot programs, state Aging officials do not expect to develop specifications for the living unit, and rather, expect that market forces will determine what is developed.

The Medicaid model will require compliance with the following Health Care Financing Administration waiver guidelines:

> Individuals shall reside in their own living units (which may include dually occupied units when both occupants consent tot he arrangement) which may or many not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. Each unit shall be separate and distinct from each other.
>
> The facility must have a central dining room, living room or parlor and common activity centers.

Services

Life Services Network of Illinois suggested services include:

Group 1 services include meals, housekeeping, security and emergency response system.

Group 2 services would include personal care, medication management, money management, intermittent health services (medication administration, dressing changes, catheter care, therapies) and other medical nursing or rehabilitative care provided by personal licensed pursuant to the Illinois Home Health Agency code and the Illinois Department of Professional Regulation).

Group 3 services include transportation, health assessment, counseling and social/educational services.

Services for the supportive living model include:

Personal care and service, homemaker, chore, attendant care, companion services, medication oversight, therapeutic social and recreational programming, 224-hour on-site response and/or other services allowed by the Health Care Financing Administration to be determined as the Supportive Living Model is developed.

Board and care

The Shelter Care Facility rules do not allow residents to be admitted or retained if they require the level of care provided in a nursing home. An exemption from this rule was granted to the demonstration projects.

INDIANA

Category Residential care facility **Model** Board and care

General approach

The state licenses residential care facilities.

A 1994 legislative study committee was formed that proposed using Oregon's definition of assisted living in a brief report.

In 1995, Senate Concurrent Resolution 35 directed the Family and Social Services Administration to conduct a study of assisted living. The Resolution directed the agency to examine the scope and effectiveness of existing assisted living programs in Indiana; the experience of other states; potential funding mechanisms; and the potential costs and savings in total state long term care expenditures that might be achieved by implementing a more comprehensive program. A committee was formed and held three public meetings, including a teleconference with participants from NASHP, AARP and the Wisconsin Bureau on Aging. A report was submitted in February 1996. The 1996 report described the definition recommended by the Indiana Association of Homes and Services for the Aging: "A congregate living situation for four or more elderly individuals designed to provide an opportunity for maximum individual choice and independence. Supportive services are provided, as needed, to main independence, individual privacy and dignity in an individual apartment setting."

The report identified 93 facilities licensed as Residential Care Facilities, about half of which participate in the state's residential care program for low income elders. In August 1995, 32 facilities described themselves as assisted living including six in the development stage.

The Family and Social Services Administration plans to continue the work group to develop a consensus on an assisted living policy. Areas of agreement included use of a certification rather than licensing process; minimum or basic criteria for being identified as assisted living to be included in the definition; availability of support services including skilled nursing and the concept of aging in place; a resident contract that covers minimum services to be offered; additional services available and selected by the resident; move out criteria; and a definition of medically complex condition.

United Seniors Action, a consumer advocacy organization, has made assisted living its priority issue for action in the 1997 legislative session.

Definition

Residential care facility means a facility that provides room, food, laundry and occasional assistance in daily living for residents who need lees services than the degree of service provided by a comprehensive care facility (nursing home). There is an overall general supervision of health care, medications and diets as defined in the written policies of the facility.

Unit requirements

Rules require 100 square feet for single rooms and 80 square feet per bed for multiple occupancy. No more than four people may share a room. One toilet and sink is required for every 8 residents.

Services

Personal care, supervision of nutritional status, assistance with self-administration of medications or administration by qualified personnel are allowed services. The rules state that “each resident shall be assisted in or occasionally given personal care as needed.”

Medication

Medications may be administered under physician’s order by licensed nursing personnel or qualified medication aids. Other treatments may be given by nurses aides upon delegation by licensed nursing personnel.

Staffing

Sufficient staff must be on duty to assure adequate care. At least one staff member must be on duty at all times in facilities with less than 100 residents and one additional staff member for every 50 residents in facilities with over 100 residents.

IOWA

Category Residential care facility
Assisted living

Model Board and care
TBD

General approach

In 1996, SF 454 was passed which creates a certification process for assisted living. The requirements will be drafted by the Department of Elder Affairs. The state will accept national accreditation from other organizations but will develop its own process for facilities that might not be able to afford the associated fees. Providers will have the option of seeking certification from the Department of Elder Affairs or another voluntary accreditation process. The Department may administer the certification program itself or contract to provide certification and monitoring. Implementation will be delayed a year until funds are appropriated to allow the Department to administer the accreditation process. Assisted living providers operational on July 1, 1996 will be granted a temporary certification for a period of one year.

Iowa has a very high supply of nursing homes beds, however, the nursing home association did not oppose the legislation. The law allows hospitals or nursing homes to convert a floor or a wing to assisted living, as long as it meets the criteria for individual apartments, or to build an assisted living facility.

Because of the high supply of nursing homes in Iowa, the supply of residential care facilities is limited and they tend to serve people with mental retardation or developmental disabilities.

Definition

"Assisted living means provision of housing with services which may include but are not limited to health related care, personal care and assistance with instrumental activities of daily living to six or more tenants in a physical structure which provides a home-like environment. Assisted living also includes encouragement of family involvement, tenant self-direction, and tenant participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk and independence. Assisted living does not include the provision of housing and assistance with instrumental activities of daily living which does not also include provision of personal care or health related care."

Unit requirements

The law directs the state fire marshall to develop rules, in coordination with the Department of Elder Affairs, concerning fire and safety standards.

Tenant policy

The law allows assisted living facilities to serve people who do not need 24 hour nursing care.

Services

The law allows a range of personal care and health related services which may be provided by the staff of the facility, individuals contracting with the facility or individuals employed by the tenant if the tenant agrees to assume the risk and responsibility of employment or the contractual relationship.

Financing

SF 454 directs the Department of Human Services to allow a certified or accredited assisted living program to be a provider under the home and community based services program waiver.

Staffing

These requirements were not addressed in the law and may be addressed through the certification standards.

Board and care

A maximum of four people may share rooms providing 80 square feet per bed. Services include personal care, assistance with self-administration and administration of medications by qualified staff. Residents may be admitted if a physician signs a statement that the resident requires no more than personal care and supervision but does not require nursing care.

KANSAS

Category Assisted living

Model New housing and services

General approach

The Kansas legislature passed a law creating an assisted living licensure category in 1995. The law creates an overall framework of adult care homes which includes nursing facilities, nursing facility for mental health, intermediate care facility for the mentally retarded, assisted living facility, residential health care facility, home plus, boarding care home and adult day care facility. The regulations differentiate among the categories of adult care homes.

Regulations implementing the law will be effective in early 1997. In addition, the Kansas Department of Social and Rehabilitative Services, the state Medicaid agency, has submitted a 1915(c) waiver application to include assisted living and residential care facilities as providers of waiver services. An effective date of January 1997 is expected for implementation of the waiver.

Definition

"Assisted living facility" means any place or facility caring for six or more individuals not related within the third degree of relationship to the administrator, operator or owner by blood or marriage and who, **by choice** or due to functional impairments, may need personal care and may need supervised nursing care to compensate for activities of daily living limitations and in which the place of facility includes apartments for residents and provides or coordinates a range of services including personal care or supervised nursing care available 24 hours a day, seven days a week for the support of resident independence. The provision of skilled nursing procedures to a resident in an assisted living facility is not prohibited by this act. Generally, the skilled services provided in an assisted living facility shall be provided on an intermittent or limited term basis, or if limited in scope, on a regular basis.

The rules provide that the administrator or operator of facilities ensure that written policies and procedures are developed and implemented which incorporate the principles of individuality, autonomy, dignity, choice, privacy and a home-like environment.

Unit requirements

Each facility must offer apartments which include areas for sleeping, living, storage, kitchen (with sink, refrigerator, stove or microwave and space for storage of utensils and supplies) and bathroom. At least 200 square feet of living space, excluding bathroom, closets, lockers wardrobes, other built-in fixed items, alcoves and vestibules. Facilities licensed prior to January 1, 1995 as an intermediate personal care facility are not required to offer kitchens and private baths.

Tenant policy

Each facility develops admission, transfer and discharge policies which protect the rights of residents. Facilities may not admit or retain people with the following conditions unless the negotiated service agreement includes hospice of family support services which are available 24 hours a day or similar resources:

- Incontinence where the resident cannot or will not participate in management of the problem;
- Immobility requiring total assistance in exiting the building;
- Any ongoing condition requiring two person transfer;
- Any ongoing skilled nursing intervention needed 24 hours a day for an extended period of time; or
- Any behavioral symptom that exceeds manageability.

Services

Facilities must develop a negotiated service agreement with each resident in collaboration with the resident, the resident's legal representative, family, if agreed to by the resident, or case manager. The agreement describes the services to be provided, the provider of service, and the parties responsible for payment when services are provided by an outside agency. The agreement supports the dignity, privacy, choice, individuality and autonomy of the resident. The agreement is reviewed **at least annually or when requested by any of the participating parties.**

Services may include meals, health care services based on an assessment by a licensed nurse, housekeeping, medical dental and social transportation, and other services necessary to support to health and safety of the resident. Health care

services include personal care, supervised nursing care, and wellness and health monitoring. The service agreement contains the skilled nursing services to be provided and the licensed person or agency providing services.

The Medicaid waiver includes assisted living facilities as a provider of respite and health care attendant services. The services covered by the waiver include respite care, sleep cycle support, health care attendant (Level I and Level II), adult day care and wellness monitoring. Sleep cycle support means "non-nursing physical assistance and supervision during the consumer's normal sleeping hours in the consumer's place of residence, excluding nursing facilities" and includes "physical assistance or supervision with toileting, transferring and mobility, prompting and reminding of medication."

Health care attendant "provides physical assistance with activities of daily living and instrumental activities of daily living for individuals who are unable to perform one or more activities independently. IADLs, excluding medication management or medication administration, may be performed without nurse supervision. These services are limited to 12 hours a day.

Level I activities include assistance with ADLs and IADLs (bathing, grooming, toileting, transferring, feeding, mobility, accompanying to obtain necessary medical services, shopping, house cleaning, meal preparation, laundry and life management).

Level II activities are health maintenance activities and include monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, medication administration/assistance, wound care, range of motion and reporting changes in function or condition. These services must be authorized by a physician or a nurse.

Reimbursement

Medicaid waiver services are available to elderly recipients who meet the nursing home level of care criteria and have income below 300% of the federal SSI payment. Rather than a flat per diem, payments are made to assisted living facilities as a provider of home and community based services. The amount of payment is based on the development of an individual care plan by a case manager. Services based on the care plan are billed fee for service. The maximum rate for health care attendant services is $12.00 per hour for Level I tasks and $13.25 per hour for Level II tasks, Care plans requiring a mix of both levels are reimbursed at the Level II rate.

Medications

Appropriate facility staff may assist with self-administration and administer medications.

Staffing

Sufficient numbers of qualified personnel must be available to ensure that residents receive services in accordance with negotiated service agreements. Facilities must provide orientation to new employees and regular in-service training on the principles of assisted living, fire safety and prevention, disaster procedures, accident prevention, resident rights, infection control and prevention of abuse, neglect or exploitation. Administrators must be licensed. Unlicensed staff must complete 40 hours of training in basic resident care skills.

Fees

$50 plus $15 for each resident.

KENTUCKY

Category Assisted living
Personal care homes

Model Multiple settings
Board and care

General approach

SB **162** was signed into law April 10, 1996 which created a licensure category for assisted living residences. The law directs the development of regulations. The law specifically exempts assisted living residences from the certificate of need law.

Definition

Assisted living residence means an apartment or home-style housing unit residence which provides assisted living to two or more adult persons who are not related within the third degree of consanguinity to the owner or operator of the apartment or residence, and which provide supportive services within the residence or on the grounds of the residence.

Unit requirements

The laws requires apartments or home-style units. An apartment is defined as a residence which shall offer at least one unfurnished room, a private bathroom with a bathtub or shower, a kitchenette, a lockable door, and individual thermostat controls. A home-style housing unit means a residence which shall offer at least one unfurnished room, a semi-private bathroom with a bathtub or shower, free use of kitchen facilities and a lockable door to the room entrance.

Tenant policy

Not specified.

Services

The law says supportive services “means, but is not limited to, transportation services; assistance with eating, bathing and dressing; assistance with personal and household activities or chores; organized social and recreational activities; assistance with self-administration of medications; monitoring of nutrition or health; and protective assistance or supervision necessary to prevent posing a health or safety hazard to the individual or others.”

Financing

Not specified.

Staffing

Not specified.

Monitoring

Not specified.

Board and care

Personal care homes provide continuous supervision of residents, basic health and health related services, personal care services, residential care services, and social and recreational activities. There are 200 facilities and 7,330 beds in Kentucky. The maximum number of beds per room is four. At least 66% of the beds in the facility must be located in rooms designed for one or two beds. Personal care homes may admit persons who are sixteen or older and who are ambulatory or mobile non-ambulatory. Persons who are non-ambulatory or non-mobile may not be admitted to a personal care home. Residents must be able to manage most of the activities of daily living. Residents must have a complete medical evaluation upon admission or within 14 days prior to admission. Residents whose care is not within the scope of services of a personal care home must be transferred to an appropriate facility.

LOUISIANA

Category Adult residential assisted living facilities

Model New Housing and services

General approach

Draft regulations creating an assisted living category are being developed by the Department of Social Services. The regulations are intended to promote the availability of appropriate services for elderly and disabled persons in a residential environment, to enhance the dignity, independence, privacy, choice and decision-making ability of residents and to facilitate aging in place by making personal care and health related services available.

The state modified its adult residential care homes regulations in 1992 as a result of Act 636 (1992). The intent of the bill was to provide for uniform minimum standards for the safety and well-being of the elderly in residential care homes.

The Medicaid budget deficit has placed enormous pressure on the state. Policy makers are interested in providing alternatives to nursing homes to reduce Medicaid spending. The state's nursing home association has run television ads stressing the quality of care and cost effectiveness of the nursing homes.

Meanwhile, the number of private assisted living facilities is expanding in the state. The number of licensed board and care homes has increased from 45 to 95.

The information relating to assisted living is based on a preliminary working draft and is described to indicate the potential direction of state policy.

Definition

Board and care home or home or boarding home or personal care home means a publicly or privately operated (twenty-four hour) residence that provides personal assistance, lodging and meals for compensation to two or more adults who are unrelated to the residence licensee, owner or administrator.

Assisted living means a coordinated array of personal care, health services and other supportive services available 24 hours per day, to residents who have been assessed to need these services. Assisted living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity and residential surroundings.

Unit requirements

Assisted living facilities would provide apartment type units with locked doors to help ensure residents their privacy, dignity and independence. Each unit shall contain areas for kitchen/kitchenette, dining, sitting, bathroom, bedroom and storage space. Efficiency apartments must have at least 180 square feet of floor space, excluding bathroom and closets. Efficiency apartments shared by two people must have a minimum of 265 square feet. No more than two residents may occupy an efficiency apartment. The living unit would be defined as an apartment, cottage or other area that contain a kitchen/kitchenette, dining area, sitting area, bathroom, bedroom and storage space within a home set aside for the use of the residents.

The draft regulations have a separate section covering bedrooms which may be shared by no more than two residents and 120 square feet for single rooms and 100 square per resident for double occupancy rooms.

Tenant policy

Residents who need continuous nursing care may not be admitted or retained, except on a temporary basis for up to 90 days, unless the care is provided by a private duty caregiver. Facilities may accept and retain people who need personal care. Residents needing further care may be served if it is agreed that the person is appropriate, that the resident can arrange for their own services,

Services

Basic services provided include three meals a day, personal and other laundry, opportunities for individual and group socialization, services to assist with ADLs and IADLs, health, social and daily living assessment, monitoring and care that by persons who are not licensed health care professionals, housekeeping, services for residents who have behavior problems and recreation services. Upon request, facilities may arrange access for medical and social transportation, ancillary services for medically related care (physician, pharmacist, therapy), barber/beauty services, hospice, home health, and routine or specialized nursing care.

Reimbursement

Not addressed as yet.

Medication administration

Assistance with self-administration of medications is a covered service in both the current and preliminary regulations.

Staffing

At least one staff person must be on premises and awake 24 hours a day and additional staff must be available to meet the standards and to provide services needed by residents. Administrators must be 21 years of age, have a bachelor's degree plus two years of experience in the field of health, social, management administration or in lieu of a degree, six years of experience and education totalling six years.

Monitoring

The Department of Health shall make at least annual inspections. Complaints are to be reviewed and investigated by the appropriate state agency.

Fee

The proposed fees would be $75 for homes serving 2-6 residents; $125 for 76-15; $175 for 16-50 and $250 for home serving more than 51 residents.

Board and care

Adult residential care home means a publicly or privately operated residence that provides personal assistance, lodging and meals for compensation to two or more adults who are unrelated to the residence licensee, owner or director. Single occupancy rooms provide 80 square feet and multiple occupancy rooms at least 60 square feet per occupant. The rules require adequate toilet, bathing and hand washing facilities. No ratios are prescribed. Each resident must have a board and care plan developed with their likes and dislikes described. Residents and their family members or representatives are involved in developing the plan. The plan must be reviewed and updated at least every three months.

Residential care facilities pay a maximum fee of $250. Actual fees are based on the size of the facility.

MAINE

Category Assisted living **Model** Multiple settings

Governor King signed legislation April 11, 1996 revising the state's assisted living program. The bill provides for several levels of assisted living and varying licensing based on the level of service provided. Assisted living services may be provided by residential care facilities and congregate housing providers. However, the licensure requirements do not apply to congregate housing providers providing only meals and housekeeping services. Licensing is optional for congregate housing providers offering personal care. Licensure is required for congregate housing providers offering personal care and administration of medication, and/or offering nursing services. Full licenses may be issued for two years if the facility is in substantial compliance with the rules and has no history of health or safety violations.

Rules are being developed by the Commissioner of Human Services which address administration, quality of care and treatment, level of qualifications of staff, rights of residents, contracts, administration of medication, sources of payment, health and safety, community relations and licensing procedures.

The number of residential care facilities has increased significantly since Maine tightened the nursing home level of care criteria in 1994. A number of nursing homes are converting wings or entire facilities to residential care. While there is no CoN requirement, the state agency issues an RFP for residential care facilities. These facilities are allowed to serve residents who need skilled services but the care must be provided by an outside agency.

Another law, Chapter 696 (1996), created a Long Term Care Steering Committee to advise the Commissioner of Human Resources on all initiatives, laws and rules concerning long term care and assisted living to ensure that these programs reflect the needs and preferences of the elderly and people with disabilities. The nine member committee appointed by the governor includes two adults with disabilities who are consumers of independent living services, two members who are family members of consumers including one who is a family member of a person with Alzheimer's Disease and five members who are over 65 years of age.

In 1996, the legislature also passed a bill that creates an expedited certificate of need review for nursing facilities which convert and de-license beds and later seek to re-license the beds as part of the nursing facility within four years.

Definition

Chapter 1665 authorizes assisted living services to be provided in congregate housing and residential care facilities. Assisted living services means the "provision by a single entity of housing and assistance with activities of daily living and instrumental activities of daily living. Assisted living services may include personal supervision, protection from environmental hazards, diet care, supervision and assistance in the administration of medications, diversional or motivational activities, assistance in activities of daily living or physical exercise and nursing services. Assisted living services must be provided by the provider of housing either directly by that provider or indirectly through contracts with persons, entities or agencies."

Residential care facilities includes "a house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services. A residential care facility includes, but is not limited to, facilities formerly defined and regulated as adult foster care homes and boarding homes." Congregate housing means "residential housing that consists of private dwelling units with an individual bathroom and an individual food preparation area, in addition to central dining facilities, and within which a congregate housing supportive services program serves occupants."

Chapter **1665** replaces the definition contained in Chapter 661 (1994) which stated: Assisted Living Services: personalized supportive services provided to functionally and/or mentally impaired adults that assist them in living in the residential environment of their choice and take into consideration their formal and informal support network. Assisted living services provider: a provider of assisted living services certified by the Department as a Congregate Housing Services Program, a residential care facility or as a home health agency.

Unit requirements

Chapter 1665 addresses requirements for living units in congregate housing through definitions. **The definition of personal care assistance implies that** only facilities consisting of private apartments can be licensed as assisted living. The definition states:

> **"Personal care assistance means services provided in group residential** settings consisting of private apartments including assistance with activities of daily living and the instrumental activities of daily living and supervision of residents self-administering medication."

In addition, the definition of nursing services also requires that they be provided in "group residential settings consisting of private apartments." However, these definitions do not apply to residential care facilities. Preliminary draft rules would require that residential care facilities provide a food preparation area, private bathrooms and lockable doors to be licensed as assisted living.

Tenant policy

Not specified.

Services

Congregate housing sites licensed as assisted living providers may offer personal assistance services, assistance with administration of medication and nursing services that are provided by licensed nurses and includes coordination and oversight of resident care services provided by unlicensed health care assistive personnel in group residential settings consisting of private apartments.

Under the new law, residential care facilities may now provide nursing services directly without contracting with or being licensed as a home health agency.

Reimbursement

The FY 97 state budget included funds to support a demonstration project for 75 units. State officials were developing a reimbursement methodology for the demonstration.

The Medicaid program provides reimbursement for personal care services in "Private Non-Medical Institutions" (Residential Care Facilities).

Medications

A separate level of licensure is required for administration of medications in residential care facilities and congregate housing sites.

Staffing

To be addressed by regulation.

Monitoring

The state ombudsman program is authorized to visit and receive and investigate complaints concerning assisted living.

Fees

Residential care facilities will pay a fee of $10 per licensed bed. The fee for congregate housing services program is $50 to provide personal care assistance, $100 to provide personal care and administration of medications and $200 to provide nursing services.

MARYLAND

Category Assisted living Model Multiple settings

General approach

In 1996, SB 545 was passed which creates a licensure category for assisted living. In 1995, a related bill failed to pass, in part because of the confusion surrounding the proposal and its relationship to existing programs. After the bill's failure, Governor Glendening created a 19 member task force as part of a Regulatory Review and Reduction Initiative. The task force issued a report on November 21, 1995. The report acknowledged that a number of programs are viewed as assisted living and found a lack of coordination among programs and differences in definitions. The report recommended creation of a uniform definition, consolidation of regulatory authority under the Department of Health and Mental Hygiene, a review of state and local fire and building codes and streamlined licensing procedures. The report recommended that the task force continue and address issues related to people with disabilities, accreditation, reimbursement and the fiscal impact, and the relationship among community based assistance services, traditional nursing homes and assisted living.

The task force proposed several levels of assisted living ranging from limited assistance to people requiring nursing care or 24 hour supervision. The Department of Health and Mental Hygiene would take the lead in drafting regulations which would not be promulgated until approved by the Director of Aging and the Department of Human Resources. The regulations were to address definitions of levels of services, quality standards, safety standards, qualifications and training of staff and other issues including a resident bill of rights.

Legislation (SB 545) filed by the task force was passed in 1996. Implementation will be phased in. New regulations converting domiciliary care to assisted living will be developed and take effect October 1, 1997. Regulations will be developed by the Department of Health and Mental Hygiene and reviewed by the Division on Aging and the Department of Human Resources.

SB 545 also modifies the Certified Adult Residential Environment (CARE) Program which provides supportive services in private homes, supervised apartments or group homes for adults with disabilities. This program, run by the Department of Human Resources, adds licensed assisted living facilities as providers.

Nursing homes are not surrendering their CoN and converting to assisted living

but some are adding assisted living. Other nursing homes are replacing older stock with new nursing homes and converting the old facility to assisted living.

Definition

SB **545** defines assisted living as "a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health related services, or a combination thereof that meets then needs of individuals who are unable to perform or who need assistance with activities of daily living or instrumental activities of daily living in a way that promotes optimum dignity and independence for individuals."

Unit requirements

Not addressed specifically in SB 545 but the intent is to provide services in a variety of settings.

Tenant policy

The law requires that a waiver process be developed that allows assisted living programs to continue to care for residents whose medical or functional condition has changed since admission if "the level of care required exceeds the level of care for which the program is licensed."

Services

Regulations will define different levels of care. Nursing home provider members sought upper limits on who could be admitted/retained in assisted living but the task force adopted a position that allows people to remain as long as the care is appropriate to the person's needs.

Reimbursement

Medicaid is not currently planning to develop reimbursement for assisted living. The agency is preparing an 1115 demonstration waiver proposal to integrate acute and long term care for dual eligibles (Medicaid and Medicare). However, the Medicaid **agency believes that an expansion of assisted living** will have an impact on the Medicaid budget. Elders are more likely to choose alternatives that are available and less expensive than nursing homes which will delay spend down. Market forces may lead to lower nursing home occupancy rates and closure of some facilities which also reduces Medicaid's exposure to future spending.

An existing waiver does cover services provided in Senior Assisted Housing which was considered assisted living prior to the adoption of the new law.

The law directs the Office of Aging to develop assisted living programs in conjunction with public or private profit or non-for profit entities, maximizing the use of rent and other subsidies available from federal and state sources. These activities can include finding sponsors; assisting developers formulating design concepts and meeting program needs; providing subsidies for congregate meals, housekeeping and personal services; developing eligibility requirements in connection with the subsidies; adopting regulations governing eligibility; and reviewing compliance with relevant regulations.

Staffing

Not address by statute.

Monitoring

Under the law, the Department of Health and Mental Hygiene may delegate monitoring and inspection of programs to the Office on Aging and the Department of Human Resources through an interagency agreement.

Fees

The law authorizes charging of fees as long as revenues do not exceed the actual costs for inspecting assisted living facilities.

Board and care

Domiciliary care homes do not admit or retain residents in need of more than intermittent nursing care. Rooms may be shared by no more than six residents. Lavatories are required for every six residents on a floor, one toilet for every six residents of the same sex on a floor and one tub/shower for every 12 residents on a floor.

The domiciliary care homes regulations will be repealed and replaced by assisted living regulations.

MASSACHUSETTS

Category Assisted living
Rest Home

Model Multiple settings
Institutional

General Approach

Chapter 354 (Acts of 1994) was signed into law in January 1995 and creates a process for the certification of assisted living facilities by the Executive Office of Elder Affairs. The law provides that the regulations "shall be sufficiently flexible to allow assisted living residences to adopt policies and methods of operation which enable residents to age-in-place." To be certified, residences must submit information such as the number of units and number of residents per unit, location of units, common spaces and egress by floor; base fees to be charged; services to be offered and arrangement for delivering care; number of staff to be employed and other information required by the Executive Office of Elder Affairs. The process does not require licensing or review of the building which must comply with state and local building codes. The buildings are considered residential use for applying codes.

Sixty assisted living residences have received deemed certification and 20 residences have been fully certified with a total of 3700 units. Reviews are pending on 6 residences. The Massachusetts Housing Finance Agency (MHFA) and the Massachusetts Industrial Finance Agency (MIFA) provide loans for assisted living. The MHFA "Elder CHOICE" program is designed to support development of appropriate housing and ADL assistance for frail elders. The agency's RFP indicates that assisted living offers a supportive residential environment which maximizes the ability of elders to live independently and reduces the need for costly institutionalization. The Medicaid Group Adult Foster Care program, which reimburses assisted living for Medicaid recipients, has certified 51 programs and ten more applications are pending. Ten of the approved providers and four of the pending proposals are assisted living residences.

Definition

Assisted living residence, any entity, however organized, whether conducted for profit or not for profit, which meets all of the following criteria:

> Provides room and board; provides, directly by employees of the entity or through arrangements with another organization which the entity may or may not control or own, assistance with activities of daily living for three or more adult residents who are not related by consanguinity of affinity to their care

provider and; collects payments or third party reimbursements from or on behalf of residents to pay for the provision of assistance with the activities of daily living.

Unit requirements

Units must be single or double occupancy with lockable doors. New construction must provide for private baths. Existing buildings may qualify if they provide private half baths and one bathing facility for every three units. All facilities must provide at a minimum either a kitchenette or access to cooking capacity for all living units. Cooking capacity is defined as each resident having access to a refrigerator, sink, and heating element. Facilities must comply with all federal and state laws and regulations regarding sanitation, fire safety, and access by persons with disabilities. The Secretary of Elder Affairs is authorized to waive the requirements for bathrooms and bathing facilities when determined to meet public necessity and to prevent undue economic hardship as long as the residence provides a home-like environment and promotes privacy, dignity, choice, individuality and independence.

Facilities must comply with all federal and state laws and regulations regarding sanitation, fire safety, and access by persons with disabilities.

Tenant policy

The statute does not allow people needing 24 hour skilled nursing supervision to be admitted or retained in an assisted living residence. Facilities may admit and retain residents in need of skilled nursing care **only if** the care will be provided by a certified provider of ancillary health services or by a licensed hospice **and** the provider does not train the facility staff to provide skilled nursing care.

To qualify for reimbursement under the Medicaid Group Adult Foster Care program, tenants must require daily assistance with at least one ADL and assistance with managing medications as documented by a physician and a nursing assessment; be at risk of requiring nursing home placement; have been discharged from a nursing home; be chronically disabled; and require 24 hour supervision.

Services

Chapter 354 requires that residences all provide or arrange for opportunities for socialization and access to community resources; supervision or assistance with ADLs identified in a plan of care (at a minimum residences must offer support for bathing, dressing and ambulation); instrumental activities of daily living; self-

administered medication management; timely assistance to urgent or emergency needs by 24 hour per day on-site staff, personal emergency response systems, or any addition response systems required by the Executive Office of Elder Affairs; up to three regularly scheduled meals per day (minimum of one meal per day). The administrator may arrange for the provision of ancillary health services in the facility but may not use facility staff for these services unless the staff is functioning as any employee of a certified provider of ancillary health services or/and an employee of a licensed hospice. Nursing services provided by a certified provider of ancillary health services such as injection of insulin or other drugs used routinely for maintenance therapy of a disease may be provided to residents.

All residents must have an individual services plan that is developed prior to admission and reviewed/reassessed at least every six months or when health status or family circumstances change.

Twenty-four hour nursing services are not allowed. Skilled services may only be provided by a certified home health agency on a part time or intermittent basis. Medical conditions requiring services on a periodic, scheduled basis are also allowed. In addition, residents may "engage or contract with any licensed health care professional and providers to obtain necessary health care services . . . . to the same extent available to persons residing in private homes." The initial draft of the regulations limited the provision of skilled services to 90 days in a one year period. The attorney general's office issued an informal opinion that such a limit was contrary to the fair housing rules and the limitation was withdrawn in the final regulations.

The MHFA Elder CHOICE program requires, at a minimum, personal care (assistance with bathing, dressing, continence, ambulation, toileting, eating and transfers); housekeeping and maintenance, laundry, medical monitoring and transportation, up to three meals a day, twenty-four hour emergency response and service coordination and case management.

Financing

The Massachusetts Housing Finance Agency and the Massachusetts Industrial Finance Agency provide loans for the construction of assisted living projects.

Services for low income tenants are subsidized through Medicaid's Group Adult Foster Care provides an average of $33.70 per day for services and administrative costs. The state had received approval from the Social Security Administration for a separate payment standard of $924 a month for single individuals in assisted living. The regular community payment standard for an aged person living alone is

approximately $550 a month. The higher standard was approved to provide a more realistic level of support for room and board which cannot be reimbursed by Medicaid for low income recipients.

Chapter 354 suspended approval of further SSI applications for the higher payment standard for assisted living residents pending a study of the economic affect of the program. The study concluded that Medicaid saves $2,398 a year per recipient through the GAFC program and the SSI assisted living payment compared to nursing home costs. Based on terminations in the GAFC program, the study estimated that nursing home admission would be delayed an average of eight months for 29% of the participants, avoided entirely for 31% of the participants'who would die and another 39% who may return to another community option. In 1996, the legislature requested a plan for controlling participation and spending using the new payment category. A report was expected to be submitted by October 15, 1996. The legislature also requested that a class rate for services be developed for GAFC providers and the maximum SSI payment be set at $900 a month. Once the plan is submitted and approved, the legislature will have to appropriate funding before it can be implemented. Action is anticipated during the 1997 legislative session.

Medications

Residence staff are allowed to remind residents to take medications, open containers, open prepackaged medications, read the label, observe, check dosage against the label and reassure residents that the proper dosage has been taken.

Staffing

No staffing specific guidelines are included concerning the type and number of staff. However, the residence must maintain an ability to provide timely assistance to residents and to respond to urgent or emergency needs through on site staffing, personal emergency response or other means. All staff and contracted providers must receive a 6 hour orientation which includes the philosophy of independent living, resident bill of rights, abuse, safety and emergency measures, communicable diseases, communication skills, the aging process and resident health and related problems. Staff providing personal care must complete an additional 54 hour training course that includes 20 hours of personal care and 34 hours of general training. The personal care component must be taught by an RN. Personal care staff will be reviewed twice a year by a qualified nurse.

The manager of an Assisted Living Residence must be at least twenty-one years old and have demonstrated administrative experience. The manager must have

a Bachelors degree or equivalent experience in human services management, housing management, and/or nursing home management. The service coordinator of a residence must have a minimum of two years of experience working with elders or disabled individuals and a Bachelors degree or equivalent experience.

Monitoring

The Executive Office of Elder Affairs conducts compliance reviews of assisted living residences. The reviews can include inspections of the common areas, living quarters (by consent of the resident), inspection of the service plans, and a review of the resident satisfaction survey.

Board and care

Rest homes provide room and board and personal care services to persons not requiring skilled nursing services. Residents who need skilled nursing services may not be retained. Home health care services may be provided in the home as long as the services are not skilled and the resident does not require 24-hour supervision. Medication administration is available, however, most residents are able to self-administer their own medications. The "responsible person" for the facility must be at least 18 years old and have a high school diploma or GED. A license is not required for this position. If the home provides medication administration, the responsible person must take a course in this area. The home must have nursing and dietary consultants. Care staff are not required to have training, although they must have access to consultations with professional disciplines.

MICHIGAN

Category Homes for the aged
Adult foster homes

Model Board and care

General approach

The state licenses homes for the aged and adult foster homes. In 1995, a work group established by the Department on Aging reviewed current trends in assisted living but decided to maintain the existing regulations. Following a reorganization of state agencies in 1996, a further review is being considered.

Definition

Homes for the aged: "A supervised personal care facility, other than a hotel, adult foster care facility, hospital, nursing home, or county medical care facility, that provides room, board, and supervised personal care to 21 or more unrelated, non-transient, individuals 60 years of age or older. Home for the aged includes a supervised personal care facility for 20 or fewer individuals 60 years of age or older if the facility is operated in conjunction with and as a distinct part of a licensed nursing home."

Adult foster homes: There are two levels of adult foster homes, those that serve 12 or fewer and those that serve between 13 and 20 residents. An adult foster care facility is a governmental or nongovernmental establishment that provides foster care to adults. Adult foster care facilities includes facilities and foster care family homes for adults who are aged, mentally ill, developmentally disabled, or physically handicapped who require supervision on an ongoing basis but who do not require continuous nursing care.

Unit requirements

Homes for the aged: Homes constructed, converted or expanded after 1981 must provide 100 square feet of usable space for single rooms and 80 square feet per resident in shared rooms. Rooms may not be shared by more than four people. Homes licensed prior to 1981 must offer at least 80 square feet of usable floor space for single rooms while shared rooms must provide 70 square feet per resident. The regulations do not limit the number of residents that may share a room. Toilet facilities are required for every eight residents per floor and bathing facilities for every 15 residents.

Adult foster homes: A single bedroom must have at least 80 square feet of usable floor space; a multi-bed room must have at least 65 square feet of usable floor space per bed. A maximum of two beds are allowed per bedroom unless the facility has been continuously licensed since the effective date of the rules or unless the resident (or the resident's representative) has agreed to reside in the multi-occupancy room, the home is in compliance with all state fire safety and environmental standards, and the bedroom provides no less than 70 square feet (65 square feet from homes licensed on or before December 31, 1976) of usable floor space per bed.

Tenant policy

Residents requiring nursing care that cannot be provided by a home health agency may not be admitted. Residents requiring 24 hour nursing care or intensive nursing care may not be retained. Physicians must certify that new residents are free from communicable diseases. Residents with a mental condition disturbing to others may not admitted or retained.

Adult foster homes may not accept, retain, or care for residents who require continuous nursing care. This does not preclude the accommodation of a resident who becomes temporarily ill while in the home, but who does not require continuous nursing care. All residents must be assessed by the facility as to the amount and type of services required by the resident. Facilities may not accept or retain residents who require isolation or restraint.

Services

Homes for the aged provide personal care. The rules require that residents wash their hands before meals and receive a bath or shower at least once a week.

Services in adult foster homes include supervision, protection, personal care, medication administration, social activities, and assistance with instrumental activities of daily living. Homes must arrange for transportation services.

Medications

No provisions.

Staffing

A sufficient number of attendants are required for each shift to assist residents with personal care under direction from supervisor.

In adult foster homes, administrators must have at least one year of experience working with persons who are mentally ill, developmentally disabled, physically handicapped, or aged. Both the licensee of the home and the administrator must complete either 16 hours of training approved by the Department of Social Services or 6 credit hours at an accredited college or university in an area approved by the Department of Social Services. Direct care staff must be at least 18 years old. The licensee or administrator must provide in-service training or make training available through other sources for direct care staff in the following areas: reporting requirements, first aid, CPR, personal care, supervision, protection, resident rights, safety and fire prevention, and prevention and containment of communicable disease.

The ratio of direct care staff in facilities for between 13 and 20 residents must be no less than one staff to 15 residents during waking hours and one staff to 20 residents during normal sleeping hours. The ratio for facilities for 12 or fewer residents must be no less than one staff per 12 residents. In all facilities there must be sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's care agreement and assessment plan.

Monitoring

Adult foster care homes are inspected by the Department of Social Services or the Department of Public Health or a local health department at the request of the Department of Social Services.

MINNESOTA

Category Boarding and lodging homes Model institutional
Assisted living (Medicaid)

General Approach

The Minnesota statute licenses boarding homes and home care service agencies that provide nursing, personal care, therapies, nutritional services, home management and others which are delivered in a place of residence. The state has implemented an assisted living program through its state funded Alternative Care (AC) program and the Medicaid Home and Community Based Services Waiver program. Licensing is provided through regulations governing home care providers.

The Alternative Care Program serves nursing home eligible residents whose income exceeds Medicaid eligibility levels but who would spend down to Medicaid levels within six months if admitted to a nursing home. The HCBS waiver covers aged and disabled Medicaid recipients who meet the nursing home criteria.

Definition

Assisted living services are defined in the home care regulations as individualized home care aide tasks or home management tasks provided to clients of a residential center in their living units, and provided either by the management of the residential center or by providers under contract with the management. Individualized means chosen and designed specifically for each client's needs, rather than provided or offered to all clients regardless of their illness, disability or physical condition. Residential centers are defined as a building or complex of buildings in which clients rent or own distinct living units. Five classes of home care may be licensed including class E, assisted living license which covers the provision of "assisted living services to residents of a residential center."

The state's Medicaid waiver defines assisted living services as "up to 24 hour oversight and supervision, supportive services, home care aide tasks and individualized home management tasks provided to residents of a residential center living in their own units/apartments with a full kitchen and bathroom. A full kitchen includes a conventional stove with an oven, refrigerator, food preparation counter space and a kitchen utensil storage compartment.

Boarding and lodging homes are defined as: "a licensed facility or unit used to provide care for aged or infirm persons who require only personal or custodial care

and related services in accordance with these regulations. A boarding care home license is required if the persons need or receive personal or custodial care only. Nursing services are not required. Examples of personal or custodial care; board, room, laundry, and personal services; supervision over medications which can be safely self-administered; plus a program of activities and supervision required by persons who are not capable of properly caring for themselves."

Unit requirements

The assisted living policies under the waiver require full apartments with kitchens. Unit size in boarding care homes is not specified in the regulations. Units with multiple beds must have cubicle curtains for privacy.

Tenant policy

Participants for the AC and Medicaid waiver programs must be screened by the county preadmission screening team and must meet the nursing home level of care criteria. Most residents fall into case mix categories A through D (see table).

Services

The Medicaid regulations allow the provision of assisted living services which include home care aide and home management tasks provided to clients of a residential center within living units and provided by management or by providers under contract with the center. Home care aide tasks are differentiated from home health aide and include assisting with dressing, oral hygiene, hair care, grooming and bathing, if the client is ambulatory and has no serious illness or infectious disease, preparing modified diets, medication reminders, household chores in the presence of technically sophisticated medical equipment or episodes of acute illness of infectious disease.

The Medicaid waiver defines services as "supportive services include socialization (when socialization is part of the plan of care, has specific goals and outcomes established and is not diversional or recreational in nature), assisting clients in setting up meetings and appointments, and providing transportation (when provided by the residential center only). Individuals receiving assisted living services will not receive both homemaking and personal care and assisted living services. Individualized means that services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illness, disabilities or physical conditions.

Under the AC and Waiver programs, residents may also receive home health and skilled nursing which are reimbursed separately from the payment for assisted living services.

Financing

Rates for services are negotiated between the client and the provider with limits based on the client's case mix classification. Service rates under the AC program cannot exceed the state's share of the average monthly nursing home payment. The client pays for room and board (raw food costs only - meal preparation is covered as a service). The cost of services in addition to assisted living services may not exceed **75%** of the average nursing home payment for the case mix classification. Under the HCBS waiver, rates for assisted living services are also capped at the state share of the average nursing home payment and the total costs, including skilled nursing and home health aide, cannot exceed 100% of the average cost for the client's case mix classification.

For room and board, the SSI payment level is $589 a'month in assisted living. The statewide maximum FY 97 service rates for elderly recipients ranged from $654 a month to $1519 a month depending upon the case mix classification. Rates in a particular county could be higher or lower than the averages. Rates for participants with physical disabilities ranged from $692 to $1557. These rates took effect October 1996 (see table).

Approximately 70% of the waiver participants fall into category A and 92.6% of the Elderly Waiver participants fall into categories A through E.

Medications

Assistance with self-administration is allowed.

Staffing

The Department of Health's standards for home care services licenses do not apply to the building itself.

Minnesota Case Mix Categories and Average Rate Limits effective 10/1/96[1]			
Category	Rate		Description
	Elderly	Disabled	
A	$654	$692	Up to 3 ADL dependencies[2]
B	$737	$776	3 ADLs + behavior
C	$832	$870	3 ADLs + special nursing care
D	$918	$956	4-6 ADLs
E	$1006	$1045	4-6 ADLs + behavior
F	$1012	$1051	4-6 ADLs + special nursing care
G	$1087	$1125	7-8 ADLs
H	$1228	$1267	7-8 ADLs + behavior
I	$1278	$1316	7-8 + needs total or partial help eating (observation for choking, tube or IV feeding and inappropriate behavior)
J	$1355	$1394	**7-8 + total** help eating (as above) or severe neuro-muscular diagnosis or behavior problems
K	$1519	$1557	7-8 + special nursing

1. The maximum rate limits vary by region of the state.
2. ADLs include bathing, dressing, grooming, eating, bed mobility, transferring, walking and toileting.

Mississippi

Category Personal Care Homes **Model** Board and care

Definition

"A personal care home" is a home or institution which is licensed to give personal care to ambulatory residents who are not in need of nursing care but who, because of advanced age and/or physical/mental infirmities, are in need of assistance with their activities of daily living ordinarily provided by responsible family members. This assistance extends beyond providing shelter, food, and laundry. Examples of such assistance includes but is not limited to the bathing, walking, excretory functions, feeding, personal grooming, dressing and financial assistance of such residents."

There are 168 facilities with 3,175 beds.

Unit Requirements

There must be at least 80 square feet for each resident in a bedroom. Residents shall not have to enter one bedroom through another bedroom. Resident bedrooms must not have more than four beds. Separate toilet and bathing facilities shall be provided on each floor for each sex.

Tenant policy

Residents must be ambulatory, have a regular diet, continent of bowel and bladder (no indwelling or external catheters are permitted), nonviolent to self and others, not require care beyond the capabilities of a personal care home and free from communicable disease. Residents who need further care or those whose medical and/or psychiatric condition(s) are not adequately controlled shall not be admitted or retained.

Residents must have a thorough medical evaluation five days prior to or at the time of admission.

Services

Personal care services, room and board.

Staffing

The administrator must be at least 21 years of age and able to read and write. There must be a responsible staff member present at all times who is at least 21 and represents the operator in his/her absence. Sufficient staff must be available at all times to provide each resident with personal care as needed. Personnel must receive training on a quarterly basis in the care of the aged or infirm. There must be one attendant per ten residents from 7:00 am to 6:00 pm and sufficient staff on hand to meet their personal care needs of residents at all other times.

Financing

Medicaid funding is not available.

Monitoring

Facilities are inspected by the Mississippi State Department of Health at such intervals as the department may direct.

MISSOURI

Category Residential care facilities **Model** Board and care

General approach

The state Division of Aging licenses two levels of residential care facilities. RCFs must obtain a certificate of need.

Definition

Type I RCFs means any premises, other than a residential care facility II, intermediate care facility or skilled nursing facility, which is utilized by its owner, operator or manager to provide twenty-four hour care to three or more residents, who are not related within the fourth degree of consanguinity or affinity to the owner, operator or manager of the facility and who need or are provided with shelter, board and with protective oversight, which may include storage and distribution or administration of medications and care during short term illness or recuperation.

The definition of Type II RCFs adds supervision of diets, assistance in personal care, and supervision of health care under the direction of a licensed physician to the definition of Type I RCFs. Facilities can be licensed to provide both levels of care within the same facility

Tenant policy

RCFs may admit or retain only residents who are capable mentally and physically of negotiating a normal path to safety using assistance devices or aides when necessary. The rules allow RCFs to admit any resident who can be cared for by the facility directly or in cooperation with community resources or other providers of care with whom it is affiliated or has contracts. Residents must be able to evacuate without physical assistance.

Unit requirements

Homes licensed after 1987 must provide 70 square feet of space per resident in both private and multiple occupancy rooms. A maximum of four residents may share a room. Homes licensed prior to 1987 could provide 60 square feet per resident. One tub/shower must be provided for every 20 residents and one toilet and lavatory for every six residents.

Services

Personal care services are reimbursed through Medicaid for residents who have chronic, stable conditions. Tasks include bathing, hair care, oral hygiene, nail care, dressing, assistance with toileting, walking or transfers, meal preparation, and light housework. Advanced personal care services include assistance for persons with altered body functions who have a catheter or ostomy, require bowel and bladder routines, range of motion exercises, applying prescription lotions or ointments and other tasks requiring a highly trained aide.

Reimbursement

Personal care and advanced personal care services are reimbursed as a Medicaid state plan service in residential care facilities. The payment varies by resident based on an assessment and a plan of care completed by a case manager from the Division of Aging. Facilities are reimbursed an hourly rate for the number of hours authorized in the plan of care. The maximum payment is $1700 a month which is tied to the state's Medicaid nursing home costs. The actual number of hours authorized ranges from 5-6 hours to 70 or 80 hours a month. The average number of hours authorized is 25-30 hours a month. The payment rate is $10.07 an hour for personal care aides, $12.11 for advanced personal care aide services and $25.00 an hour for nursing visits. No more than one nursing visit a week can be authorized. Very few residents receive advanced personal care and nursing visits.

The room and board rate is paid through the federal SSI payment and a state "cash grant" or SSI supplement payment. Type I facilities receive a combined payment of $645 a month and Type II facilities receive a combined payment of $752 a month. With an average personal care payment of $302.10, the total payment would equal $947 in Type I facilities and $1054 in Type II facilities.

Fees

Licensing fees are $100 for facilities of 3-25 beds; $300 for 25-100 beds; and $600 for 100+ beds.

MONTANA

Category Personal care facilities
Adult foster care homes

Model Board and care

General approach

The state's Medicaid HCBS waiver reimburses services provided personal care facilities and adult foster care homes. Neither the licensing rules nor the waiver uses the term assisted living.

Definition

Personal Care Facilities: A facility in which personal care is provided for residents in either a category A facility or a category B facility. A facility must have a license for either category A or category B. Category A means the residents can self medicate, are mobile, continent and generally in good health. Category B means residents may be ventilator dependent, incontinent, under chemical or physical restraint, or IV dependent. A facility that does not have a category B license may obtain one if the residents in the facility decline in health. Facilities may have up to five residents who fall in this category.

There are 58 facilities and 892 beds in Montana.

Unit requirements

No more than four residents may reside in a single bedroom. Each single bedroom must contain 100 square feet and each multi-bedroom must contain at least 80 square feet per bed, excluding toilet rooms, closets, lockers, wardrobes, alcoves or vestibules.

Each resident must have a wardrobe, locker, or closet with minimum clear dimensions of 1'10" in depth by 1'8" in width, with a clothes rod and shelf placed to permit a vertically clear hanging space of 5' for full length garments. Each resident must have access to a toilet room without entering another resident's room or the kitchen, dining, or living areas. There must be one toilet room for every four residents and one bathing facility for every 12 residents. For each multiple-bed room, either flame-resistant cubicle curtains for each bed or movable flame-resistant screens to provide privacy upon request of a resident must be provided by the facility.

Tenant policy

PCFs may provide personal care services to a resident who is 18 or older and in need of the personal care for which the facility is licensed. A resident in a facility licensed as a category A facility may obtain third party provider services for skilled nursing care for no more than 20 consecutive days at a time. A resident of a category B facility must have a signed statement from a physician agreeing to the resident's admission to the facility if the resident is: in need of skilled nursing care; in need of medical, physical, or chemical restraint; non-ambulatory or bedridden; has no bowel or bladder control; or is unable to self-administer medications. Category B facility residents must have signed statement renewed every quarter by a physical, physician assistant, nurse practitioner, or a registered nurse who visited the facility within the calendar quarter covered by the statement and has certified that the resident's need can be met in the facility. Category B facilities may serve five or fewer residents with the needs defined above.

Standards for operating a category B facility must include the standards for a category A facility (standards for physical, structural, environmental, sanitary, infection control, dietary, social, staffing, and record keeping components of the facility) as well as standards for assessment of residents, care planning, qualifications, and training of staff, restraint use and reduction, prevention and care of pressure sores, incontinence care, and the storage and administration of drugs.

Residents of category B facilities must be assessed upon admission for mobility, mental status, physical status, self-medication, dietary needs, personal hygiene needs, and social needs. Within three days after admission a care plan must be developed that is prepared by a licensed health care professional, and to the extent practicable, with the participation of the resident, the resident's family, or the resident's legal representative. Care plans must be updated at least quarterly.

Services

Services include: residential services, such as laundry, housekeeping, food service, and either providing or making available provision for local transportation; personal assistance services with ADLs; recreational activities; and supervision of self-medication. Personal care assistance is provided while encouraging residents to maintain independence and a **sense of self-direction.**

Reimbursement

The room and board payment under SSI is $564 a month. The Medicaid waiver

reimburses adult foster care home and personal care facilities between $520 and $1800 a month depending on the level of care needed by residents. State agency field staff complete the assessment and determine the payment rate. In addition to the room and board component, the basic service payment for residents is $520 a month. Additional payments are calculated based on ADL and other impairments. Points are calculated for each impairment. The functions measured are: bathing, mobility, toileting, transfer, eating, grooming, medication, dressing, housekeeping, socialization, behavior management, executive cognitive functioning and other. Each function is rated 1, (with aides/difficulty; people who need consistent availability of mechanical assistance or expenditure of undue effort); 2, (with help: requires consistent human assistance to complete the activity but the individual participates actively in the completion of the activity) or 3, (unable: the individual cannot meaningfully contribute to the completion of the task).

Each point equals $33 a month. For example, a resident consistently needing help with toileting would be scored a two and would earn $66 a month for that impairment. Residents with severe impairments, totally dependent in more than three ADLs can receive $44 a month for each point. The total payment (services and room and board) ranges from $1084 to $2363 a month although very few participants have been approved at the highest rate. About 40 recipients are receiving this service under the HCBS program.

Medications

Staff may assist with self-administration of medications. Licensed health care professionals may set up daily dose containers, verify physician's orders, and set up injectable medications.

Staffing

Each PCF must employ an administrator who must at all times be responsible for the PCF and ensure 24-hour supervision of the residents and have completed high school or have a general education development (GED) certificate. Administrators must also evidence at least six hours of annual continuing education in one of the following areas: resident and provider rights and responsibilities, abuse/neglect, or confidentiality; basic principles of supervision; skills for working with residents, families, and other professional service providers; characteristics and needs of residents; community resources; accounting and budgeting; or basic and advanced emergency first aid. Personal care staff must receive and orientation to providing services to residents.

Monitoring

Unannounced on-site surveys are conducted annually, biannually, or triennially depending on whether the facility has been granted an extended license. Individuals served under the HCBS program are reassessed every six months or more frequently if needed.

Fees

$70 per bed for category A facilities and $90 a bed for category B facilities.

NEBRASKA

Category Residential care facility **Model** Board and care

General approach

A task force was organized in 1995 to discuss assisted living options. During consideration of covering assisted living as a Medicaid service, questions were raised about the net impact on total expenditures and whether adding the service would reduce nursing home occupancy in a state with a very high supply of beds. A review of nursing home residents indicated that 1520% have no nursing needs and very limited ADL impairments. Previously, the state's nursing home system reimbursed nursing homes based on costs. Lower occupancy rates spread fixed costs across a smaller number of beds, thereby increasing rates. Nursing homes are now penalized when occupancy rates drop below 90%. To adjust, homes have reduced the number of licensed beds to avoid the rate penalty.

In 1996, a Managed Long Term Care Work Group was formed to develop recommendations for the future of state's long term care system. The work group will consider where assisted living fits in the broader system. A report is expected to be issued in the spring of 1997.

The Department of Health has also formed a task force to revise the residential care facility rules. The group consists of Department staff, associations and providers. A model that allows overlap with the residents served in nursing homes is likely. Significant revisions in the current rules are anticipated as a result of the work of the task force.

Definition

Residential care facility means any institution, facility, place or building in which there is provided for a period exceeding twenty-four consecutive hours accommodation, board, and care, such as personal assistance in feeding, dressing, and other essential daily living activities, to four or more non-related individuals who by reason of illness, disease, injury, deformity, disability, or physical or mental infirmity are unable to sufficiently or properly care for themselves or manage their own affairs, but who do not require the daily services of a licensed registered or practical nurse.

Unit requirements

Single bedrooms must have 80 square feet and multiple occupancy rooms, 60

square feet per bed with no more than four beds per room. One lavatory is required for every six residents and one shower/tub for every 15 residents.

Tenant policy

Not specified. Licenses may not be issued to operate a residential care facility if a portion of the facility provides any type of nursing, medical or nursing home care to any or all residents of the residential care facility.

Services

Care, activities and social services may be provided. “Care” includes but “is not limited to the maintenance of a minimum amount of supervision of the activities of daily living as well as the providing of a minimum amount of assistance to the residents, and shall also include personal care, hereby defined as the provision of health-related services for individuals who are in need of a protective environment but who are otherwise able to manage the normal activities of daily living.”

Reimbursement

Medicaid funds are not available.

Medications

Facilities may administer routine oral and external medications.

Staffing

The facility must provide staff to be in charge of the facility at all times who shall be awake and dressed during their tour of duty.

Monitoring

Not specified.

Fees

Not specified.

NEVADA

Category Residential Facilities for Groups **Model** Board and care

General approach

These regulations cover small facilities (<7 beds) and larger facilities (7 or more). Chapter 449 was amended 1 1/8/94 and new regulations may go into effect in October 1996). A small Medicaid waiver reimburses homes for personal care in residential facilities for groups.

Definition

An adult group home for the elderly or disabled is a facility which provides care to two or more elderly or disabled persons requiring assistance and supervision due to aging, infirmity, or handicap. People with Alzheimer's disease are usually served in separate homes, typically those with fewer than seven beds.

There are 200 facilities with 4-6 beds, and there are several larger facilities.

Unit requirements

In small facilities (< 7), two residents may share a bedroom. Single rooms must provide a minimum of 80 square feet and shared rooms (two people) at least 60 square feet per resident. Facilities must have sufficient bathrooms and toilets to accommodate employees and other persons at the facility. Doors of bedrooms may be equipped with locks for use by residents if the doors may be unlocked from the corridor and keys are readily available. Provisions must be made for privacy in all bathrooms and for all toilets located in bedrooms for use by more than one resident.

Facilities that admit people with Alzheimer's disease must have 24-hour awake staff, weekly inspection of the fire alarms, and an inspection of the sprinkler system every 3 months. Exit doors must have alarms or time-delay locks. Local audible alarming units must be installed.

Larger facilities (> 7) may allow three people to share a bedroom and offer at least 80 square of space per bed. Toilets and lavatories must be provided for every four residents and a tub or shower for every six residents.

Tenant policy

Facilities with fewer than seven beds may admit people who are 18 or older, need protective supervision, and desire to live as a member of a group. Facilities may admit only one resident at any given time who is confined to a wheelchair or requires the use of a walker. People with Alzheimer's disease must ambulate or transfer to a primary form of ambulation with prompting and be able to evacuate the building within 2 minutes. Facilities may not admit any person who cannot get himself in and out of a wheelchair, or who cannot move with a walker without assistance; requires restraint or confinement in locked quarters; or requires nursing under daily medical supervision.

Facilities with seven or more residents may admit an ambulatory person who uses a cane only if he is given a room with a direct exit to the outside or is placed in a room on the ground floor which is within a reasonable distance from an exit to the outside. These facilities may not admit a person who has an easily transmitted contagious or infectious disease, requires restraint or confinement, is subject to attacks of epilepsy which are not medically controllable, requires treatment for addiction to alcohol or drugs, or requires treatment for mental illness unless the illness is controlled by self-administered medication.

Residents must be transferred to an appropriate medical facility at any time their physical and mental condition reaches the point that they cannot meet the standards of health described above.

Services

Facilities provide protective supervision, laundry, activities and temporary storage of medications. Larger facilities must also provide personal care services and must have a schedule that provides a framework for daily living that includes meals at regular hours, the hour for rising and retiring, work assignments, religious activities and group activities. Temporary illnesses may be cared for in the facility through home health, however, the regulations did not indicate if the facility must arrange for services or if it is the resident or resident's advocate's responsibility.

Medication

Facilities may only oversee the taking of medication.

Reimbursement

Personal care services are reimbursed through a Medicaid HCBS in group

residential settings if they meet the SSI eligibility criteria. Facilities receive a total payment of approximately $1000 a month which includes $781 from SSI for room and board and $9.09 a day ($277.20 a month) for personal care. The state has approximately 35 recipients participating in the waiver. Participation has been lower than expected. Because the residential care program was designed to serve people needing an hour of personal care a day, participants have preferred to remain in their homes and participate in a similar waiver. As needs increase, facilities have not felt prepared to provide a higher level of care.

Staffing

For larger facilities, staffing must be sufficient to provide a quality of services which will meet the needs of residents on a 24 hour basis and assure adequate and speedy evacuation in case of emergency.

Administrators of facilities with fewer than seven beds must be at least 21 years old, have a high school diploma or GED, furnish evidence that they are responsible and reputable character, and be responsible and mature and have the personal qualities which will enable them to understand the problems of the aged and disabled. Administrators of facilities with seven or more beds have the same requirements except they must also have had a minimum of three years of experience in the care of groups or a closely related field. Employees of all facilities must show evidence that they are physically healthy and must be of good character and personal integrity. Staff of homes serving people with Alzheimer's disease must have a minimum of eight hours of state-approved continuing education each year.

Monitoring

Facilities are subject to on-site inspections and complaint investigation.

NEW HAMPSHIRE

Category	Supported Residential Care Facilities Residential Care Home Facilities	**Model**	**See** general approach

General approach

State policy does not use the term assisted living, however, state contacts indicated that their approach supports assisted living in a number of settings. Home health agencies provide assisted living services in apartments and a number of apartment complexes advertize themselves as assisted living. In addition to home care services, two residential levels of care are licensed. Residential Care Home Facilities and Supported Residential Care Facilities. Supported Residential Care Facilities provide a higher level of care than Residential Care Home Facilities. The latter are not allowed to provide nursing services and provide guidance for assistance with ADLs rather than hands on assistance. There are 84 residential care facilities with 1,071 beds and 49 supported residential care facilities with 1,390 beds.

Definition

"Residential care facilities, whether or not they are private homes or other structures build or adapted for the purpose of providing residential care, offering services beyond room and board to two or more individuals who may or may not be elderly or suffering from illness, injury, deformity, infirmity or other permanent or temporary physical or mental disability. Such facilities include those:

> 1. Offering residents home-like living arrangements and social or health services including, but not limited to, providing supervision, medical monitoring, assistance in daily living, protective care or monitoring and supervision of medications; or
>
> 2. Offering residents social, health, or medical services including, but not limited to, medical or nursing supervision, medical care or treatment, in addition to any services included under subparagraph (1). Such homes or facilities shall include, but not be limited to, nursing homes, sheltered care facilities, rest homes, residential care facilities, board and care homes, or any other location, however, named, whether owned publicly or privately or operated for profit or not."

The statute indicates that residential care requires a minimum of regulation and reflects the availability of assistance in personal and social activities with a minimum of

supervision or health care, which can be provided in a home or home-like setting. Supported residential health care reflects the availability of social or health services, as needed, from appropriately trained or licensed individuals, who need not be employees of the facility, but residents shall not require nursing services complex enough to require 24 hour nursing supervision. Such facilities may also include short-term medical care for residents of the facility who may be convalescing from an illness and these residents shall be capable of self-evacuation. Supportive residential care serves residents who do not need 24 hour nursing care except on a short term basis. Residents need help with ADLs but must be able to evacuate with assistance. Residential care homes are a step below supported residential care facilities and provide supervision and some ADL assistance.

Unit requirements

Units must have at least 80 square feet per one bed room and 140 square feet per room with two beds, exclusive of space required for closets, wardrobe, dressers and toilet room. Rooms may be shared by two people. Sinks, toilets, tubs and showers shall be available for every six residents.

Tenant policy

Residential care homes can accept only those persons who are 1) mobile and can self evacuate; 2) able to initiate and accomplish most activities of daily living but may require supervision or physical assistance; 3) not in need of licensed or professional nursing or monitoring except for temporary episodic illness.

Persons admitted for short stays must have a health examination conducted within 30 days prior to admission and include any orders and medications required by the resident; an assessment focused on the services needed by the resident; and an admission agreement which lists the services to be provided during the residence.

Persons admitted for more than a short term stay must have a health exam conducted within 30 days prior to admission which addresses medical requirements; functional activities and limitations; medication needs and orders; and dietary needs; the administrator or designee in conjunction with the resident's provider and family/guardian must complete an initial assessment prior to admission; the administrator must ensure that assessments are completed at least every six months; and the resident must receive a written list of services that will be provided; a list of services for which additional payment is required; rules of the home; information on, and procedures for, reserving a place in the home when the resident is hospitalized or out of the home for a period of time; grounds for termination of agreement; and

notification required for involuntary transfer for reasons other than emergency situations.

Residential care homes may not accept any resident whose assessment indicates services are required which the facility cannot provide.

Supported residential care facilities may accept only residents who are mobile and can self-evacuate, are able to initiate and accomplish some ADLs with help but require physical assistance and prompting with others, require intermittent, short term 24 hour nursing care or less than 24 hour nursing care on an ongoing basis, require consultation or direct care for therapeutic services (physical, occupational, recreational therapy and mental health services), or require administration of medications.

Services

Residential care homes. Services include protective services including supervision, arrangement of appointments, crisis intervention, supervision in activities of daily living, nutrition and medications, and provision of or arrangement for transient medical care with licensed home health care providers; access to community services; room and board.

If a resident's health status changes permanently to non-mobile or the resident requires medical or nursing care on an ongoing basis, the home must either provide medical or nursing care from a licensed home health care provider on a contract basis; seek licensure to provide a higher level of care; or transfer the resident to another facility where medical and nursing care are available.

The home is responsible for arranging the provision of additional services to residents requiring care during a temporary episodic illness or convalescence following acute hospital care.

Supported residential care facilities provide housekeeping, verbal and physical assistance with ADLs, nutrition monitoring, meals, personal supervision when required to offset cognitive deficits that pose a risk to self or others, assistance with medications (verbal prompting, reminding and some physical assistance) and provision for administration of medications by appropriately licensed persons directly or by contract with a licensed home health agency and for treatments ordered by a physician. Facilities shall provide or arrange with a licensed home health agency for short term intermittent nursing care and less than 24 hour nursing or other medical monitoring care on an ongoing basis.

Medication

Administration of medications by licensed staff is allowed.

Staffing

Administrators must be at least 21 and never convicted of a misdemeanor or felony. Administrators of facilities licensed for 4 to 16 beds must have a high school diploma or GED plus one year of work experience in a health field; or an associates degree from an accredited college or university in a health field.

Administrators of residential care homes licensed for 17 or more residents must have a high school diploma plus 5 years of direct care experience; an associate's degree from an accredited college or university plus 3 years of experience in a health or human services field; or a bachelor's degree in a health field. Administrators must have 12 hours of continuing education each year.

Residential care homes do not require medical directors or directors of nursing. Other staff must be at least 18 years old if they provide direct care, never have had a felony conviction, and never have been convicted of abuse, assault, neglect, or exploitation of any person. Personnel must have ongoing in-service or continuing education that addresses areas of weakness identified by the administrator during annual performance reviews. In-service and continuing education acceptable for this purpose should also address the special needs of the residents such as medication supervision or administration; first aid; behavior management; personal care; fire safety and evacuation; socialization; and residents' rights.

Monitoring

The licensing agency conducts annual inspections of facilities.

Fees

$2.50 per bed.

NEW JERSEY

Category Assisted living **Model** Multiple settings

General approach

Regulations took effect in December 1993 governing the provision of assisted living services in assisted living residences and comprehensive personal care homes. The regulations are intended to promote aging in place in homelike, apartment style settings for frail elders. The purpose section of the regulations describes the goals of assisted living to "maintain independence, individuality, privacy, dignity" in an environment that "promotes resident self direction and personal decision making while protecting health and safety." The Board of Nursing approved applying a medication administration rule for all three categories of assisted living, which allow unlicensed staff, who are certified and under the supervision of a licensed registered nurse, to administer medications, in specific circumstances, to assisted living residents.

Proposed regulations creating a third assisted living setting, assisted living programs in subsidized housing sites, were submitted in August 1996 to the Health Care Administration Board which reviews and approves all regulations. ALP regulations permit licensing of a service agency to deliver services in subsidized elderly housing projects. Regulations were supported by the associations representing home health agencies and home care agencies.

As of September 1996, 10 licenses had been issued containing 657 beds' four of which were assisted living residences and six were issued to personal care homes. Another 140 applications are under construction and have been approved but not yet licensed and between 20-30 further application were under review. The number of beds in licensed facilities, beds approved but not licensed and applications under review total over 19,000. Three of the ten licensed facilities are CCRCs. All new construction is purpose built, apartment style units. Only facilities licensed by the Department of Health and Senior Services prior to December 1993, the effective date of the assisted living regulations, can convert to comprehensive personal care homes and offer bedrooms rather than apartment style units with a kitchenette. The state has adopted an expedited certificate of need review for assisted living residences.

State officials expect that the supply of nursing homes and residential care facilities will remain stable while the supply of assisted living units rises.

[1] The Department of Health's procedures track beds rather than units.

Definition

Assisted living "means a coordinated array of supportive personal and health services, available 24 hours per day to residents who have been assessed to need these services, including residents who require formal long term care. Assisted living promotes resident self direction and participation in decisions that emphasize independence, individuality, privacy, dignity and homelike surroundings."

Assisted living residence means a facility which is licensed by the Department of Health to provide apartment-style housing and congregate dining and to assure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette and a lockable door on the unit entrance.

Comprehensive personal care home means "a facility which is licensed by the Department of Health to provide room and board and to assure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units may house no more than two residents and have a lockable door on the unit entrance."

Assisted living program "means the provision of or arrangement of meals and assisted living services, when needed, to the tenants of publicly subsidized housing which because of federal, state or local housing laws, regulations or requirements cannot become licensed as an assisted living residence. An assisted living program may also provide staff resources and other services to a licensed assisted living residence and a licensed comprehensive personal care home."

Unit requirements

Each assisted living residence unit must offer a minimum 150 square feet of clear and useable floor area (excluding closets, bath and kitchen), private bathroom, a kitchenette and a lockable door on the unit entrance. The kitchenette must include a small refrigerator, cabinet for food storage, sink, and space with outlets suitable for cooking appliances such as a microwave, cook top or toaster oven." An additional 80 square feet of floor space must be provided for an additional person occupying a unit. No more than two people may occupy a unit.

Personal care home units must provide 80 square feet for single occupancy units and 130 square feet if the unit is occupied by two people.

Assisted living programs are licensed as a service. Requirements for the

apartments in subsidized housing projects are specified by the source of financing.

Tenant policy

Assisted living is not appropriate for people who are not capable of responding to their environment, expressing volition, interacting or demonstrating independent activity. Each resident receives an assessment and a care plan by a registered nurse. The residence may, but is not required to, care for people who require 24 hours, seven day a week nursing supervision, are bedridden longer than 14 days, consistently and totally dependent in four or more ADLs, have cognitive decline that interferes with simple decisions, require treatment of stage three or four pressure sores or multiple stage two sores, are a danger to self or others or have a medically unstable condition and/or special health problems. The admission agreement has to specify if the facility will retain residents with one or more of these characteristics and the additional costs which may be charged. The facility must also describe the assessment process and the manner in which the resident and/or their family will be involved.

With ten licensed facilities the experience with these criteria has been limited. Applications show a bell shaped curve with most facilities selecting 3-4 conditions which they will serve. A few on either end will not serve people with any of the eight criteria while a similar number will serve people meeting all eight criteria.

Services

The residence must provide or arrange personal care and services. The minimum service capacity must include personal care, nursing, pharmacy, dining, activities, recreation, and social work services to meet the individual needs of residents. Supervision, assistance with and administration of medications by trained and supervised personnel is also required. Facilities must also be capable of providing nursing services to maintain residents.

New rules for assisted living programs require contracts between service providers and the housing entity. The contracts provide that tenants will not be barred from participation because of the location of a unit, tenants cannot be moved because of their participation, housing owners/managers must agree to the provision of services and establish policies to ensure at least one staff on site 24 hours a day.

Financing

A Medicaid home and community based services waiver was effective in 1996

that allows the state to serve 1500 residents, starting with 500 residents in 1996 and increasing 500 a year over three years, in assisted living and adult family care settings. Rates have been developed for each of the three settings. Each service rate includes an amount for waiver services and $300 for state plan services. Assisted living residences receive $550 for room and board from SSI and $2100 a month for Medicaid services. Assisted living programs receive $1500 a month for services. Residents are charged a percentage of their income for room and board. Personal care homes receive $550 for room and board and $1800 a month for services.

Medicaid officials plan to review their methodology to refine the rate methodology.

New Jersey Rate Schedule

	Assisted living residences	Assisted living programs	Personal care homes
Room and Board	$550.55	NA'	$550.55
Medicaid waiver services	$1800.00	$1200.00	$1500.00
Medicaid state plan services	$300.00	$300.00	$300.00
Total	$2650.55	$1500.00	$2350.55

Note: Assisted living program residents live in subsidized housing and are charged a percentage of their income for rent. In addition to the room and board payment in ALRs and ALPs, residents receive a personal needs allowance of $69 a month.

Medications

Residences are allowed to provide supervision of and assistance with self-administration of medications and administration by trained and supervised personnel. Registered nurses may delegate medication administration to personal care assistants who have completed required training and passed a written test.

Staffing

The regulations require at least one awake personal care assistant and one additional staff at night and sufficient staffing to provide the services indicated by the assessments of resident needs. A registered nurse must be available on staff or on

call 24 hours a day. Administrators must either be licensed as a nursing home administrator or complete an assisted living training course approved by the Department of Health and Senior Services and a written test within one year of their employment as an administrator. The course includes 40 hours of classroom training and a 16 hour practicum. In addition they must complete 10 hours of continuing education a year. Personal care assistants must complete a nurses aide training course, a homemaker-home health aide training program or equivalent training approved by the Department of Health.

Fees

Licensure fees are $500 plus $10 per bed. Assisted living programs pay a fee of $750.

NEW MEXICO

Category	Residential shelter care Assisted living (Medicaid)	Model **Model**	Board and care Service in multiple settings

General approach

The state has added assisted living as a Medicaid waiver service. Providers may be licensed adult area residential shelter care homes or new or innovative programs. The program has signed agreements with 6 contractors although few recipients have joined the program.

Definition

Medicaid. Assisted living is a special combination of housing and personalized health care service designed to respond to the individual needs of waiver recipients who require assisting with activities of daily living (ADL's e.g., ability to perform tasks that are essential for self care, such as bathing, feeding oneself, dressing, toileting, and transferring) and instrumental activities of daily living (IADL's, e.g., ability to care for household and social tasks to meet individual needs within the community). Assisted living is based on the following fundamental principles of practice: individuality, independence, privacy, dignity, choice and a home-like environment. Assisted living services are packaged per individual recipient needs.

Unit requirements

Services must be provided in "home-like" environments which are defined as:

1. A minimum of 220 square feet of living and kitchen space (not including bathroom) for newly constructed units (rehabilitated units must provide a minimum of 160 square feet).

2. Adult residential shelter care homes must provide 100 square feet of floor area in a single bedroom (excluding closet/locker). Recipients must have access to a common living area, kitchen and bathroom which are handicapped accessible. 80 square feet is required for semi-private bedrooms.

Services

An inter-disciplinary team develops an individualized service plan which is

approved by the Department of Health waiver staff. Staff from the facility participate as a member of the team and attend team meetings.

Core services provide minimum to moderate assistance and include at a minimum: bathing, dressing, eating, personal hygiene, behavior management, opportunities for individual and group interaction, housekeeping, laundry, transportation, meal preparation and dining, twenty-four hour response capability to meet routine scheduled care as well as unscheduled, unpredictable needs of the recipients, capacity to provide on-going supervision of the waiver recipient within a twenty four hour period, service coordination capability to arrange access to services not provided directly, provider. participation in the interdisciplinary team meetings for development of the individualized service plan and demonstrated capability to address the most common dementia related problems (e.g., memory loss, depression, sleep disorders).

In addition to the above core services, providers may provide personal services (specialized bowel and bladder program and catheter care); private duty nursing (medication management, nursing services such as injections, wound care, health status monitoring and assessment); skilled maintenance therapies (PT, OT, speech); emergency response services; and other support services authorized by the Department of Health designed to maintain independence.

Services may be provided by the facility or another approved waiver provider.

Reimbursement

The Department of Health has established an interim service rate of $49.50 per day (excluding room and board) for approved provider agencies. The Department of Health and Department of Human Services reviews reports filed during the first quarter to determine a final rate. The Department will consider setting a base rate with add-ons for other services (eg., therapies) as well as negotiated rates. Room and board charges must be submitted to the Department of Health prior to the provision of services. The waiver set eligibility at 200% ($940 a month) of the federal SSI payment and recipients may keep income below $940 to cover maintenance needs. The maintenance allowance was set based on recipients living in their own home/apartment and an adjustment may be made for recipients in assisted living.

Staffing

The waiver guidelines require staffing ratios and patterns that will meet the individual recipient's needs as identified in the ISP.

Board and care

"Adult Residential Shelter Care Home" means "a facility which accepts and provides care for residents who have physical or mental disabilities." This type of facility "must provide assistance in daily living activities, such as, but not limited to: bathing, shaving, brushing of teeth, dressing, eating, laundry, cleaning of room, managing money, shopping, using public transportation, writing letters, making telephone calls, obtaining appointments, self administering of medications, recreation and leisure activities, and obtaining medical and dental services when needed. Daily observation of the resident's physical condition must be made." This type of facility is licensed for at least 3 but not more than 15 residents. There may be an exception made for facilities with more than 15 beds if the facility meets the construction standards in the Uniform Building Code and the Life Safety Code.

A Shelter Care Facility may accept up to 2 residents who are not mobile for each staff member on duty, up to a maximum of 4 non-mobile residents. These facilities must be able to evacuate residents within 8 minutes.

Private rooms must have at least 100 square feet of floor area, not including closets and locker areas. Semi-private rooms shared by no more than 2 people must have at least 80 square feet of floor area per bed, not including closets and locker areas. Toilets, sinks, tubs, and showers must be provided in ratios of 1 for every 8 residents, with separate facilities for each sex.

In adult residential shelter care homes "residents who require periodic professional nursing care are permitted if the facility has an RN or LPN on staff, or if such nursing care is either on an out-patient basis, or provided by a visiting nurse service.

Administrators must be at least 21 years old, of good character, demonstrate basic respect of the dignity of residents, be physically, mentally, and emotionally fit to operate these facilities, have management and administrative abilities to fulfill the regulations, be able to communicate with the residents and staff in the language spoken by the majority of the residents and other employees, and have a high school diploma or GED. Other staff of these facilities must be at least 18, of good character, have adequate education, training or experience to provide for the needs of the residents, and be physically, mentally, and emotionally equipped to carry out responsibilities of resident care.

NEW YORK

Category Assisted living (Medicaid) **Model** Multiple settings

General Approach

A Task Force on Long Term Care Financing issued a report in 1996 that make broad recommendations on long term care. A section of the report recognized that assisted living has been developed "as an alternative for low income people who would otherwise require nursing facility placement." The report recommends that the program be reformed "to require licensure of assisted living as a specific type of enhanced home care service under the auspices of one State agency." Currently, the program falls under two laws, one licensing adult care facilities and the other licensing home care agencies. The report recommended allowing the residential component to be provided in any type of residential setting, including adult care facilities that meet building requirements such as the State Uniform Fire Prevention and Building Code. A series of outcome based program requirements would be set for fire safety, nutrition, medication management and case management.

The New York Task Force saw assisted living taking a prominent place in the state's overall long term care strategy and affecting the need for nursing home beds. The report recommended a re-examination of all components of the nursing facility bed need methodologies for long term care that reflects projected demographic trends, expected changes in utilization patterns based on increases in managed care penetration, addition of new services options (eg., assisted living) and potential changes in utilization based financing recommendations.

In 1991, the state legislature created a 4200 bed assisted living program (ALP). Since the program substitutes for nursing home beds, the nursing home bed need formula was reduced by an equivalent amount. By 1994, 63 projects totalling 3500 units had been contingently approved through a state contracting process. As of October 1996, 31 sites were operational. An RFP was issued in 1996 for 700 units in New York City which remained from the initial RFP. The second RFP brought proposals from 34 providers requesting a total of 3,000 units. The proposals have been reviewed and the beds awarded to six applicants.

The state approaches assisted living as a service option in existing housing. Assisted living programs must be licensed as an adult home or enriched housing program (which addresses housing) and licensed as either a home care services agency, a certified home health agency or a long term home health care agency (which addresses home care service delivery).

Oversight is provided by two state agencies. The Department of Health reviews licenses for licensed home care agencies and the Department of Social Services licenses adult homes and enriched housing.

Adult homes and enriched housing programs are both licensed under the state's adult care facility regulations. Both models serve five or more people and provide long term residential care, room, board, housekeeping, personal care and supervision. Adult homes represent the state's board and care model while enriched housing programs operate in community integrated settings resembling independent housing units. While the majority of Assisted Living Program beds are in adult homes, the demand from "enriched housing" providers is increasing among purpose built facilities rather than conventional elderly housing sites.

Definition

Assisted Living Program (ALP): An entity which is approved to operate pursuant to section 485.6(n) of this Title, and which is established and operated for the purpose of providing long term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible adults unrelated to the operator.

Unit requirements

Adult homes provide single or double occupancy bedrooms and have one toilet and lavatory for every six residents and one tub/shower **for every 10 residents.**

Enriched housing programs must provide single occupancy units, unless shared by agreement, and each unit must include a full bathroom, living and dining space, sleeping area and equipment for storing and preparing food. Shared units must provide for toilets, lavatory, shower or tub shared by not more than three residents.

Tenant policy

To receive Medicaid reimbursement for home care services provided in an ALP, applicants must be determined by a physician to be appropriate for this level of care. The applicant must then be assessed by the ALP to determine the care required and **the program's ability to meet those needs. Participants must have stable medical conditions and** are able to assure self-preservation in an emergency. Operators may not serve anyone who: requires continual nursing or medical care; is chronically bedfast or chair-fast and requires lifting equipment or two person assist for transfer; or is cognitively, physically or medically impaired to a degree which endangers the safety

of the resident or other residents.

Services

Adult homes and enriched housing programs can provide supervision, personal care, case management, activities and food service under their adult care facilities license. To operate as an assisted living program, additional services and licenses are needed. The facility may seek a license to provide nursing care and therapies or they may contract with a home health agency or a long term home health care program.

The capitation rate covers personal care, home health aide, personal emergency response services, nursing services, physical therapy, occupational therapy, speech therapy, medical supplies that do not require prior authorization and adult day health care, if needed.

A care plan is jointly developed by the ALP and the CHHA/LTHHCP which is based on the physician's orders and the-assessment process.

Financing

For Medicaid recipients, the home care service reimbursement is set at 50% of the resident's Resource Utilization Group (RUG) which would have been paid in a nursing home. The state has created 16 RUG categories for 10 geographic areas of the state. The attached chart includes approved rates for 1996. Facilities must comply with the adult home retention criteria. However, the full array of rates are shown since facilities receive a higher rate when a resident deteriorates and is retained until a nursing home placement can be made.

The reimbursement category is determined through a joint assessment by the Assisted Living Program and the designated home health agency or long term home health care program. The assessment and the RUG category are reviewed by the Department of Social Services district office which must prior authorize the Medicaid home care payment.

The residential services (room, board and some personal care) are covered by SSI which also varies by region. In 1996, the SSI rates were $905 in New York City, Nassau, Suffolk and Westchester counties and $875 in the rest of the state. Using the four lowest RUG categories and the SSI rates, the total monthly rate in New York City ranges from $1706 to $2516.

Medication

Assistance with self-administration is allowed including prompting, identifying the medication for the resident, bringing the medication to the resident, opening containers, positioning the resident, disposing of used supplies and storing the medication.

Staffing

Adult homes must have a case manager and staffing that is sufficient to provide the care needed by residents. Staff providing personal care must complete a personal care aide or home health aide training course or other examination approved by the state Department of Health.

Proposed RUG Rates in New York State										
RUG	Albany	NYC	Syra-cuse	Roches-ter	Orange	Long Island	Erie	West-chester	Utica	Pough-keepsie
CA	$44.81	$64.16	$47.99	$45.27	$48.84	$59.66	$41.83	$56.06	$41.78	$45.61
BA	$44.47	$63.76	$47.65	$44.86	$48.47	$59.28	$41.52	$55.63	$41.52	$45.24
PA	$37.91	$53.47	$40.84	$38.45	$41.12	$49.62	$35.50	$47.11	$35.58	$38.69
PB	$48.13	$69.71	$51.53	$48.41	$52.51	$64.87	$44.82	$60.49	$44.77	$48.96
RA	$67.80	$100.54	$72.07	$67.79	$74.42	$93.83	$62.78	$86.19	$62.41	$68.83
RB	$73.60	$109.87	$78.21	$73.47	$80.80	$102.61	$68.02	$93.88	$67.56	$74.75
SA	$66.25	$98.11	$70.48	$66.31	$72.65	$91.56	$61.34	$84.24	$60.96	$67.34
SB	$72.62	$107.45	$76.98	$72.80	$79.79	$100.32	$67.23	$92.41	$66.65	$73.78
CB	$57.39	$84.40	$61.28	$57.52	$62.79	$78.68	$53.24	$72.68	$53.06	$58.36
CC	$61.07	$90.22	$65.11	$61.10	$66.89	$84.16	$56.61	$77.47	$56.38	$62.05
CD	$69.63	$103.59	$74.06	$69.57	$76.40	$96.71	$64.40	$88.69	$64.01	$70.74
BB	$53.35	$78.12	$57.05	$53.48	$58.30	$72.79	$49.56	$67.36	$49.47	$54.23
BC	$59.18	$87.41	$63.19	$59.22	$64.76	$81.51	$54.84	$75.07	$54.66	$60.17
PC	$53.35	$78.12	$57.05	$53.48	$58.30	$72.79	$49.56	$67.36	$49.47	$54.23
PD	$57.05	$84.02	$60.95	$57.13	$62.42	$78.32	$52.93	$72.24	$52.78	$58.00
PE	$63.36	$94.23	$67.65	$63.30	$69.36	$87.92	$58.63	$80.64	$58.38	$64.45

Note: ALPs receive one half the rate listed.

CA = Clinically complex A
BA = Severe behavioral A
PA = Reduced physical functioning A
PB = Reduced physical functioning B
RA = Heavy rehab A
RB = Heavy rehab B
SA = Special care A
SB = Special care B
CB = Clinically complex B
CC = Clinically complex C
CD = Clinically complex D
BB = Severe behavioral B
BC = Severe behavioral C
PC = Reduced physical functioning C
PD = Reduced physical functioning D
PE = Reduced physical functioning E

NORTH CAROLINA

Category Assisted living residences **Model** Multiple settings

General Approach

Legislation (Chapter 535) was passed the end of July 1995 that converts domiciliary care or rest homes to adult care homes which are called assisted living residences. The law also adds a category of assisted living residence called multi-unit assisted housing with services. The multi-unit assisted housing with services category was effective July 1, 1996. Permanent regulations have been adopted. Funding for personal care was approved effective August 1, 1995.

The legislation was based in part on the work of a 31 member "Steering Team" which made recommendations to the Secretary of the Department of Human Resources. The recommendations would establish assisted living as an umbrella concept that includes a variety of models in two basic categories -- multi-unit independent housing and adult care homes, including family care homes. The Team included state and county agencies, advocacy groups, nursing home, housing and adult care home providers, legislators and others. The group met nine times between August 1993 and January 1995 and five subcommittees were formed that met regularly between meetings. The Team established four goals for the model:

- assure that adults of all ages and adults with disabilities receive high quality care and services;
- protect individuals' safety and well-being;
- reserve individual rights and dignity; and
- allow diversity in service delivery models.

Quality of care would be assured through the development of outcome measures rather than rules that rely on structure and process.

Multi-unit assisted housing models have to register with the Division of Facility Services and provide a disclosure statement to residents. The statement describes the emergency response system, charges for services offered, limitations of tenancy and services, resident responsibilities, financial relationships between housing management and home care or hospice agencies, a listing of all home care or hospice agencies in the area, an appeal process and procedures for annual screening and referrals for service.

The Division of Facility Services published guidelines for multi-unit assisted

living residences in August 1996. A work group was to be formed in July to revise the rules for Adult Care Homes.

Definition

> "Adult care home" is an assisted living residence in which the housing management provides 24 hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies.
>
> "Assisted living residence" means a group housing and services program for two or more adults, by whatever name it is called, which makes available, at a minimum, one meal per day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care agencies. Assisted living residences are to be distinguished from nursing homes subject to the provisions of G.S. 131 E-l 02. Effective October 1, 1995 there are two types of assisted living residences: adult care homes and group homes for developmentally disabled adults. Effective July 1, 1996, there is a third type, multi-unit assisted housing with services.
>
> "Multi-unit assisted housing with services" means "an assisted living residence in which hands on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency, through an individualized written care plan." Multi-unit assisted housing with service programs are required to register with the Division of Facility Services and to provide a disclosure statement.

Unit requirements

Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or common baths. Residential building codes apply to adult care homes serving six or fewer residents and institutional codes to adult care homes service more than six residents.

Adult homes may serve up to four residents per bedroom. Bedrooms must be 100 square feet, excluding vestibule and closet, for single rooms and 80 square feet per bed for multiple occupancy rooms. One bathroom must be provided for every five residents and a shower for every 10 residents.

Tenant policy

Adult care homes may not care for people who are ventilator dependent, require continuous licensed nursing care, individuals whose physician certifies that placement is no longer appropriate, individuals whose health needs cannot be met in the specific adult care home as determined by the residence and people with such other medical and functional care needs as the Social Services Commission determines cannot be properly met.

The disclosure statement for multi-unit assisted housing with services programs is required to be part of the rental agreement and covers the emergency response system, charges for services, limitations of tenancy, limitations of services, resident responsibilities, the financial and legal relationships between the housing management and home care or hospice agencies, a listing of all home care or hospice agencies in the area, an appeals procedure and procedures for initial and annual resident screening and referrals for services.

Unless the individual's physician determines otherwise, multi-unit assisted housing with services may not care for people who are ventilator dependent, have dermal ulcers stage III and IV, except stage III ulcers that are healing, take psychotropic medications without appropriate diagnosis and treatment plans, have nasogastric tubes or gastric tubes except when the individual is capable of independently feeding themself or is managed by a home care or hospice agency, individuals requiring continuous nursing care, and individuals who require maximum assistance with four or more ADLs and who meet the nursing home level of care criteria.

Services

At a minimum residences must provide one meal a day and housekeeping services. Personal care may be provided directly or through contracts. Nursing services may be provided by the residence on a case by case exception basis approved by the Department. However, nursing services can be provided through licensed home care agencies. The Social Services Commission has the authority to limit nursing services provided by assisted living residences.

Financing

Personal care in adult care homes is reimbursed as a state plan service through Medicaid. The SSI payment for room and board is $874 a month (less a personal needs allowance). The Medicaid payment varies with the needs of the residents. The basic payment is $8.07 a day which assumes each resident receives one hour of personal care a day. Homes receive higher payments for residents with

extensive or total impairments in three specific ADLs: eating, toileting or both. The rate for residents with extensive or total impairments in eating is $16.00 per day, toileting $10.87 per day and impairments in both eating and toileting are reimbursed at $18.80 per day. These three payment levels include the basic rate of $8.07 per day. Eligibility for the added payment is based on an assessment by the adult care home which is then verified by a county case manager.

North Carolina Medicaid Rates - monthly				
	Basic rate	Eating	Toileting	Eating & toileting
Room and board	$874.00	$874.00	$874.00	$874.00
Personal care	$242.70	$480.00	$326.10	$564.00
Total	$1116.70	$1354.00	$1200.10	$1438.00

Medication

Medications must be administered in adult care homes by designated and trained staff.

Staffing

Personal care aides performing heavy care tasks need 75 hours of training and all other personal care aides receive 40 hours of training, with at least 20 hours of classroom instruction that covers basic nursing skills; personal care skills, cognitive, behavioral and social care; basic restorative services; and resident's rights. Personal care aides in family care homes must receive 20 hours of training.

Monitoring

County Departments of Social Services monitor adult care homes at least every other month. State staff provide consultation, technical assistance and training to the county monitors. State staff also provide oversight and perform an annual on-site survey of each facility with seven or more **beds.**

NORTH DAKOTA

Category	Basic Care Facility Assisted living (Medicaid)	**Model** **Model**	Board and care Services in apartment setting

General Approach

The state reimburses assisted living through its Medicaid Home and Community Based Services Waiver and state funded service programs. Assisted living is viewed as a service in an apartment setting. Licensing is not required, however, the public welfare statute contains a definition of assisted living. While only one provider participates in the program, state officials note that interest from other potential providers has increased. The current site is a mixed population site funded by HUD for people with mobility impairments. The state assisted living programs provides services to residents in fifteen of the twenty apartments.

Definition

Assisted living: An environment where a person lives in an apartment like unit and receives services on a twenty-four hour basis to accommodate the person's needs and abilities and maintain as much independence as possible.

Basic care facility: a facility licensed by the department . . . whose focus is to provide room and board and health, social and personal care to assist the residents to attain or maintain their highest level of functioning, consistent with the resident assessment and care plan, to five or more residents not related by blood or marriage to the owner or manager. These services shall be provided on a 24 hour basis within the facility, either directly or through contract, and shall include assistance with ADLs and IADLs; provision of leisure, recreational and therapeutic activities; and supervision of nutritional needs and medication administration.

Unit requirements

The assisted living guidelines require an apartment setting.

Basic care facility: single rooms provide 100 square feet, double rooms at least 80 square feet per bed and rooms for three or more, 70 square feet per bed. At least one toilet is required for every four residents and one bath for every 15 residents.

Tenant policy

Participants in the service programs must have needs that can be met through the program. To qualify for services, residents must have impairments in 4 ADLs or impairments in 5 IADLs totalling 8 points (see below) or 6 points if the person lives alone.

Basic care facility: While an admission policy was not outlined in the regulations, a "resident" was defined as "an individual admitted and retained in a facility in order to receive room and board and health, social, and personal care who is capable of self-preservation, and whose condition does not require continuous; twenty-four-hour a day on site availability of nursing or medical care."

Services

The Medicaid waiver program provides environmental and personal services to participants.

Basic Care Facilities provide personal care (ADLs, IADLs, and observation and documentation of changes in physical, mental, and emotional functioning, as needed); arrangements to seek health care when needed; arrangement for transfer and transportation as needed; assistance with functional aids, clothing, and personal effects as well as maintenance of personal living quarters; assistance with medication administration; and social services. Nursing services must be available to meet the needs of residents either by the facility directly or arranged by the facility through an appropriate individual or agency.

Financing

The state has four sources of financing: an HCBS waiver for the aged, blind and disabled, an HCBS waiver for people with traumatic brain injuries, and two state funded programs - a service payment for elderly and disabled and the exceptional service payment for the elderly and disabled. The programs pay providers a rate based on the care needs of the resident. The maximum rate is $50 a day. A point system is used to convert unmet service functional needs to a rate (see table). The total points are multiplied by a factor of 8 to obtain a monthly payment rate.

Medications

Medicaid waiver. The state's nurse practice act allows assistance with self-administration but not the direct administration except by licensed staff. No separate

requirements outside the nurse practice act are included.

Basic Care Facilities must make available medication administration services.

Staffing

Staff must be able to deliver the necessary services required by plans of care.

Basic care facilities. There must be awake staff on duty 24 hours a day. The facility must establish educational programs to orient new staff and improve employees' abilities to carry out their responsibilities. Employees must have annual in-service training on: Fire and accident prevention and safety, mental and physical health needs of residents, prevention and control of infections, and resident rights. Administrators must attend at least 12 hours of continuing education annually; dietary staff must attend at least 2 dietary education programs annually; and staff responsible for activities must attend at least 2 activity-related education programs annually.

Monitoring

On site, unannounced surveys are conducted by the department to determine compliance with regulations. Plans of correction must be developed by the facility if deficiencies are found. Corrections must be completed within 60 days of the survey completion date unless the department has approved an alternative schedule. The department will follow up on all plans of correction. Enforcement actions include a ban or limitation on admissions, suspension or revocation of license, or denial of license.

North Dakota Point System			
Activity		**Value**	
Taking Medication	1	Foot Care	10
Temp\Pulse\Resp\BP	1	Nail Care	10
Managing Money	1	Change Dressings	10
Communication	1	Apply Elastic Bandage	10
Shopping	6	Care of Prosthetic	10
Housework	6	Medical Gases	10
Laundry	6	Meal Preparation	20
Mobility	6	Exercise	20
Transportation	6	Water Bath/Heat	20
Bathing	15	Ostomy Care	20
Teeth/mouth care	15	Bowel Program	20
Dress/undress	15	Indwelling Catheter	20
Toileting	15	Bronchial Drainage	20
Transfer	10	Feeding/eating	20
Continence	15	Supervision Level I	15
Eye Care	10	Supervision Level II	30
Skin Care	10		

OHIO

Category Residential care homes **Model** Board and care

General Approach

In July 1993, chapter 3726 was signed which created an assisted living program. In April 1994 the Department of Health issued draft regulations and a Medicaid Home and Community Based Services Waiver proposal was submitted to HCFA. Implementation of the program was planned for July 1, 1994. As the process for developing the regulations proceeded, segments of the assisted living and nursing home industries expressed concerns about the model and the direction of the regulations. An amendment was passed that delayed the effective date of regulations pending a review by a special committee consisting of 6 legislators, four state agencies, four provider groups (three nursing home and one assisted living), the Area Agency on Aging Association, the Ombudsman Association, AARP and a taxpayer group.

The task force was created to address opposition to Chapter 3726 and the proposed regulations dealing with the unit requirements, the level of services provided in assisted living and the medical conditions of tenants. While a formal consensus report was not submitted, the governor's budget included several proposals contained in the draft report. The 1995 budget bill repealed the assisted living statute and created a new category of residential care facility to replace the rest home classification. Residential care facilities are able to provide up to 120 days of skilled nursing services with exceptions for special diets, medication administration and dressing changes. Rules were approved by the Public Health Council and were effective September 29, 1996 implementing the new changes.

Legislation (SB 60) requiring criminal background checks for staff working with elders was passed by the legislature in 1996.

Definition

Homes for the aging means a home that provides services as a residential care facility and a nursing home, except that the home provides its services only to individuals who are dependent on the services of others by reason of both age and physical or mental impairment.

Residential care facilities means a home that provides either of the following:

1. Accommodations for seventeen or more unrelated individuals and supervision of personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment.
2. Accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or physical or mental impairment and to at least one of those individuals, any of the skilled nursing care authorized by section 3721 .01 1 of the revised code.

Chapter 3726 defined an assisted living facility as "a multiple unit residential facility, other than . . . that provides or arranges for skilled nursing care for one or more individuals who reside in the facility and are not related to the owner or operator of the facility or his spouse as a parent, grandparent, child, sibling, niece, nephew or child of an aunt or uncle."

Unit requirements

RCFs must offer 80 square feet for single occupancy rooms and 70 square feet per person in multiple occupancy rooms. No more than four people may share a room. A toilet, sink, tub/shower is required for every eight residents.

The repealed law specified that the facility must consist of single occupancy units (unless shared by choice) containing private cooking, bathing, washing, and toilet facilities, has doors that can be locked and individual temperature controls, is equipped with automatic sprinkler equipment. The facility must be approved by the local building department rather than the Health Department.

Tenant policy

The statute allows facilities to serve residents requiring skilled care for up to 120 days. Exceptions to the 120 day limit allow residents to receive dressing changes, special diets and medication administration.

Repealed: Assisted living facilities may not admit anyone who requires skilled nursing care on a 24 hour a day basis or retain a resident for a period longer than is necessary to complete an appropriate transfer. Residents requiring 24 hours of care for more than 30 days, **or have medically complex** needs requiring constant nursing supervision, assessment, planning or intervention or require direct supervision of licensed nursing personnel may not be served.

Services

Allowed nursing services include supervision of special diets, application of dressing, administration of medication and other services on a part time, intermittent basis for a total of not more than 120 days in any twelve month period. Part time or intermittent is defined as less than 8 hours a day or less than 40 hours a week. Previously the law allowed skilled services for 35 days if provided by a certified home health agency. The new rules allow skilled services to be provided by the RCF or a hospice agency in addition to a home health agency.

The repealed law provided that an assisted living facility must provide or arrange for services needed or requested by the resident such as skilled nursing care, supervision, personal care services including assistance with self-administration of medications, homemaker services, therapies and other services specified by the Director of the Department of Health. A home and community based services waiver application was submitted, and later withdrawn, to HCFA to finance services for Medicaid recipients. The governor's budget includes funding for waiver services. A waiver has been delayed pending a review of the state's entire Medicaid program.

Financing

The budget proposal included $4.4 million for the Department of Aging to develop an assisted living program through a Medicaid Home and Community Based Services waiver and to subsidize room and board payments. In 1995, the Department of Aging developed a five tiered system for determining the level of reimbursement (see table). Rates would range from $200 to $1400 a month. A residential State Supplement (SSI) of $700 a month will be paid to cover room and board costs. A decision on submission of the waiver for federal approval had not been made as of September 30, 1996.

Medications

Non-licensed staff may assist with self-administration. Activities include reminders, observing, handing medications to the resident, verifying the resident's name on the label, removing oral or topical medications from containers, applying medication upon request, placing containers with medication to the mouth of the resident.

Staffing

At least 1 staff member must be on-site at all times. In addition, sufficient staff

time must be available to meeting in a timely manner the residents' care, supervisory and emotional needs and reasonable requests for service, including ongoing supervision of residents with increased emotional needs or presenting behaviors that cause problems for the resident or other residents and to properly provide dietary, housekeeping, laundry and facility maintenance services and recreational activities. An RN, LPN or physician must be on duty when medications are being administered. Staff may be shared with other licensed facilities in the same building or in the same lot as long as staffing requirements for all facilities are met.

Monitoring

The facility must be inspected once every 15 months by the Department of Health and the fire marshall (state or local).

Fees

Licensing and renewal fee of $100 for every 50 persons, or part thereof of licensed capacity.

Ohio Assisted Living Waiver Service Levels	
Service Level	Minimum Waiver Service Needs
One	• Assistance with 2 secondary ADLs
Two	• Assist with 1 primary ADL & 1 secondary ADL; or • Level one + medication administration; or • Level one + behavior management; or • Level one + plus unstable medical condition; or, • Level one + daily skilled nursing services not covered under the state Medicaid Plan
Three	• Assist with 4 ADLs (any type); or • Assist with 3 ADLs (including 1 primary ADL) plus medication administration; or • Level two plus behavior management: or • Level two plus unstable medical condition; or • Assist with 3 ADLs (including one primary ADL) plus daily skilled nursing services not covered under the state Medicaid Plan.
Four	• Assist with 5 ADLs (any); or • Assist with 4 ADLs (any) plus medication administration; or • Level three plus behavior management; or . Level three plus unstable medical condition; or • Assist with 4 ADLs (any) plus daily skilled nursing services not covered under the state Medicaid Plan.
Five	• Assist with 5 ADLs plus medication administration AND daily skilled nursing services not covered under the state Medicaid Plan; or • Level four plus behavior management; or • Level four plus unstable medical condition.

OKLAHOMA

Category	Residential care homes	**Model**	Board and care
	Assisted living (proposed)	**Model**	Multiple settings

General approach

A task force proposed legislation, HB 2909, which was considered during the 1996 session. The bill was developed with support from the nursing home association, the Board of Nursing, advocates and assisted living providers. However, it was not reported to the floor because of controversy over changes proposed by a multi-state assisted living provider. The company proposed that the full range of nursing services be added to the list of allowable services. The bill may be re-filed during the 1997 session. The process was useful in educating legislators and increasing the commitment of advocates to seek passage of the legislation. The following material is based on the legislation developed for the 1996 legislative session.

The bill states that the purpose of the statute was to contribute to the development of a comprehensive long term care system by establishing community based assisted living services programs that provide a home-like environment for older persons and persons with developmental, physical or mental disabilities who need assistance with activities of daily living or assistance with instrumental activities of daily living.

The findings section describes that assisted living incorporate a philosophy that respects consumer privacy, dignity and right to make decisions and be included in every aspect of his/her own care. Consumers should be allowed to make informed choices about where and with whom to reside, type of residential setting, lifestyle patterns, needs and preferences for services, service providers and method of delivery.

The bill would create an assisted living advisory committee to advise the legislature and governor on revising statute and rules, protecting the rights of consumers, monitoring programs, developing sanctions for programs which are out of compliance and training requirements. The committee would consist of two providers, representatives from the departments of health, human services, rehabilitative services, mental health, representatives for persons with physical disabilities, mental disabilities, elders and three consumers.

The regulations would be developed by the Department of Health and submitted to the legislature within six months. The regulations would cover training for

administrators and direct care staff, physical environment requirements, development and implementation of resident service plans, development of service contracts and other issues. In lieu of licensing, the Department would be authorized to accept accreditation by any national body whose standards meet or exceed those of the state. A fee of $50 would be required for all licensure applications. Settings would receive either a probationary license (120 days) or a two year license.

Definition

Assisted living setting was defined as a group residential setting and environment that is home-like in character and appearance where assisted living services are provided to two or more consumers who are not related to the owner of the setting by blood or marriage.

Unit requirements

Rules would be developed for small settings (housing six or fewer residents), and large settings (seven or more). The living units must be private with a bathroom and space for food storage/preparation, sleeping and living areas, shared only by consent. Units must have lockable doors, mailboxes and controllable thermostats.

Tenant policy

Admission/retention criteria would be determined through regulation. Managed risk is defined in the bill as "a process which allows a consumer or the consumer's representative to evaluate and choose, after discussion with all relevant parties, including the administrator or operator of the assisted living services program, the risks associated with each option when making decisions pertaining to the consumer's abilities, preferences and service needs."

The state Board of Health would establish rules governing pets. Programs seeking to allow residents to have pets would apply to the Board. Consumers would not be transferred without receiving the right to determine the degree of safety or security measures needed and to assume reasonable risk. Residents may be transferred or discharged for medical reasons, the resident's safety, the safety of other residents or non-payment subject to rules developed by the Department of Health.

Services

Services would include personal care, housekeeping, medication assistance, transportation, monitoring of health and functional status, routine nursing service to

managed medically predictable recurring needs and service coordination. Personal care must be available 24 hours a day to meet unscheduled needs.

State law allows nurses to delegate tasks that are within the scope of their license to perform. Nurses remain responsible for all nursing care that a person receives under their direction. Nurses may use their professional judgement in determining which tasks may be delegated. Tasks which may not be delegated include those which require nursing assessment, judgement, evaluation and teaching during implementation such as physical, psychological and social assessment which require nursing judgement, intervention, referral or follow up; formulation of a plan of nursing care and evaluation of responses to the care, administration of medications except as authorized by regulations.

Reimbursement

Not addressed.

Medications

To be addressed by regulation.

Staffing

Staffing patterns would be described in the facility's licensure application. Operators must be 21 years of age or older and may not have been convicted of a felony in conjunction with management of a facility.

Monitoring

The Department of Health would be responsible for monitoring assisted living setting through review of reports and inspections which shall be based on outcome measures, Less frequent monitoring will be allowed for facilities which demonstrate exemplary service. Rules will be developed based on the size of the facility.

Board and care

Residential care homes provide accommodations, food services, and supportive assistance (housekeeping, assistance with meal preparation, storage, distribution and administration of medications and assistance with personal care) to residents who are ambulatory and capable of managing their own affairs, but do not routinely require skilled nursing care or intermediate care. One toilet for every six residents and one

tub/shower for every ten residents is required. Single rooms provide 80 square feet and multiple occupancy rooms, 60 square feet per resident. The rules do not specify a maximum number of residents per room. Administration of medications by qualified personnel is allowed.

OREGON

Category Assisted living **Model** **New** housing and services

General Approach

The state adopted assisted living regulations and policies in 1992 to substitute for nursing home care and offer home-like environments which enhance dignity, independence, individuality, privacy, choice and decision making. Facilities are required to have written policies and procedures which describe how they will operationalize these principles.

A total of 69 facilities with 3200 units were licensed as of the end August 1996 with six new facilities receiving licenses during the last week. Thirty more facilities are under construction or in planning stages. Medicaid recipients occupied 858 units the end of August. Several facilities are being financed through the HUD 232 mortgage insurance program.

Definition

"Assisted living means a program approach, within a physical structure, which provides or coordinates a range of services, available on a 24 hour basis, for support of resident independence in a residential setting. Assisted living promotes resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and home-like surroundings."

Unit requirements

Each unit must provide 220 square feet of space, not including a private bathroom. Units in pre-existing structures may provide 180 square feet. Units must have kitchen with a sink, refrigerator, cooking appliance and space for food preparation and storage, individual heat controls, lockable doors and a phone jack. Buildings must meet applicable zoning and building codes.

Tenant policy

The regulations specify "move out" criteria that allow residents to choose to remain in their living environment despite functional decline. Facilities may ask residents to leave if the resident's behavior poses an imminent danger to self or others, if the facility cannot meet the resident's needs or services are not available, for non-payment or if the resident has a documented pattern of non-compliance with

agreements necessary for assisted living.

Services

An interdisciplinary team conducts an assessment with each resident and develops a plan that responds to their needs. Services include assistance with ADLs, nursing assessment, health monitoring, routine nursing tasks, medication assistance, housekeeping, three meals a day, laundry, and opportunities for socialization that utilize community resources.

Each facility must also have the capability to provide or arrange for medical and social transportation, ancillary services for medically related care, barber/beauty services, social/recreational, hospice, home health care and maintenance of a personal financial account for residents.

Financing

The state provides five levels of payment for services to Medicaid recipients residing in assisted living settings. Residents must meet the nursing home level of care criteria. A room and board payment of $396.70 is paid in addition to the service rate. The levels are assigned based on a service priority score determined through an assessment (see table below). ADLs include eating/nutrition, dressing/grooming,- bathing/personal hygiene, mobility, bowel and bladder control and behavior.

Oregon Service Priority Categories and Payment Rates

Impairment Level	Service Priority	Service	R&B	Total rate
Level V	**Service priority A or priority** B **and dependent** in the behavior ADL.	**$1586**	**$396.70**	$1982.70
Level IV	Service priority B or priority C with assistance required in the behavior ADL.	$1283	$396.70	$1679.70
Level III	Service priority C or priority D with assistance required in the behavior ADL.	$978	$396.70	$1347.70
Level II	Service priority D or priority E with assistance required in the behavior ADL.	$736	$396.70	$1132.70
Level I	Service priority E or F or priority G with assistance required in the behavior ADL.	$553	$396.70	$949.70

Medications

The regulations allow residents to keep medications in their unit if they are capable of self-administration. Facilities are allowed to administer medications and they must have policies and procedures which assure all administered medications are reviewed every 90 days.

Staffing

The regulations do not specify staffing requirements. Each facility must have sufficient staff to deliver the services specified in resident plans of care.

Monitoring

State or Area Agency on Aging staff conduct periodic monitoring visits. Staff review compliance with state rules and written outcome measures which reflect planned and actual results covering functional abilities, psycho-social well being, stability of medical conditions and client/family satisfaction.

Fees

A licensing fee of $60 is required.

Board and care

Rules for residential care facilities were revised January 1994. Two levels of care are licensed. Facilities with a Class I license may serve people who need assistance with, but are not totally dependent in, ADLs who are ambulatory. Class II licenses allow facilities to serve people who are aging-in-place, have higher medical acuity or are dependent in one or more ADLs. Facilities licensed after January 1994 must provide rooms with a minimum of 80 square feet per person. No more than two people may share a room. Toilets and sinks are required for every six residents and bathing facilities for every ten residents.

Service Priority Categories	
Category	**impairments**
A	Dependent in 3-6 ADLs
B	Dependent in 1-2 ADLs
C	Requires assistance in 4-6 ADLs
D	Requires assistance in 3 critical ADLs
E	Requires assistance in 2 critical ADLs
F	Requires assistance in 3 ADLs
G	Requires assistance with 1 critical ADL and meets conditions of at least 1 other essential factor or requires assistance with 1 critical ADL and 1 less critical ADL.

Note: critical ADLs are bowel and bladder control, eating/nutrition, behavior/cognition; less critical ADLs are dressing/grooming, bathing/personal hygiene, mobility.

PENNSYLVANIA

Category Personal care homes **Model** Board and care

General approach

The state licenses personal care homes as an institutional model. State officials report considerable pressure and controversy to modify the regulations. One group seeks to re-name personal care boarding homes as assisted living without changing the regulations. This group fears that unlicensed homes will provide a personal care level of service and personal care homes will provide nursing home level of care under more stringent regulations and higher costs. Others support creating a new category of assisted living that will provide more services than are currently allowed by the personal care home regulations.

About 100 assisted living facilities are presently licensed as personal care homes. Others are not licensed because they do not provide a level of personal care that requires licensure.

Definition

"A premises in which food, shelter and personal assistance or supervision are provided for a period exceeding 24 hours for four or more adults who are not relatives of the operator, who do not require the services in or of a licensed long term facility, but who do require assistance or supervision in matters such as dressing, bathing, diet, financial management, evacuation of a residence in the event of an emergency or medication prescribed for self-administration."

Unit

The regulations require single occupancy rooms to have at least 80 square feet of floor space. If closets are built, they must be at least 9 square feet and can be counted in the total required space. Multiple occupancy rooms must have at least 60 square feet per person. No more than four people may share a bedroom. Toilets must be available for every six residents, and tubs or showers for every 15 residents.

Services

Services include personal care services provided by trained, qualified staff and with ongoing oversight and general supervision by the administrator. Personal care tasks include hygiene (bathing, oral hygiene, hair grooming and shampooing, dressing

and care of clothes and shaving), and tasks of daily living (securing transportation, shopping, making/keeping appointments, care of personal possessions, correspondence, personal laundry, social and leisure activities, securing health care, ambulation, use of prosthetic devices and eating. Home health services may be provided by a certified agency, including hospice care, as long as the physician indicates that the person is appropriate personal care homes and the service is needed for a temporary period.

Medication

Assistance with self medication includes storing, reminders and offering the resident the medication at the prescribed times.

RHODE ISLAND

Category Assisted living **Model** Institutional

General Approach

The state's regulations use the term "residential care and assisted living facilities." There are 50 facilities and 1,466 beds licensed. The program is equivalent to board and care.

Definition

"A publicly or privately operated residence that provides directly or indirectly by means of contracts or arrangements personal assistance, lodging, and meals to two (2) or more adults. ... Residential care and assisted living facilities include sheltered care homes, and board and care residences, or any other entity by any other name providing the above services which meet the definition of residential care and assisted living facility." There are four levels of licensure for residential care and assisted living facilities. A residence may have areas within the facility that are licensed separately. The levels are

a) Level F1: licensure for residents who are not capable of self preservation; and/or
b) Level F2: licensure for residents who are capable of self preservation; or
c) Level Ml: licensure for residents who require that the facility centrally store and administer medications;
d) Level M2: licensure for residents who require assistance (as elaborated in section 19.3.1) with self-administration of medications;
e) Or combination per area of facility.

Unit Requirements

Resident rooms may have no more than two beds. Single rooms must have at least 100 square feet in area, and double bedrooms must be at least 160 square feet in area. There must be at least one bath per 10 beds and one toilet per 8 beds or fraction thereof on each floor where residents' rooms are located and not otherwise serviced by bathing facilities within the resident's room. There must be an area within the resident's bedroom and/or facility to be under lock for the safe keeping of personal possessions.

Tenant Policy

Residents must be adults, not requiring medical or nursing care as provided in a health care facility, but who may require the administration of administration of medication. A resident must be capable of self-preservation in emergency situations, unless the facility meets a more stringent life safety code; or residents must be reasonably oriented and not require care beyond that permitted by the level of service for which the facility is licensed.

Services

Twenty-four hour adult staffing; personal services; assistance with self-administration of medication or administration of medications by appropriately licensed staff; assistance with arranging for supportive services that may be reasonably required; monitoring health, safety, and well-being; and reasonable recreational, social and personal services. Nurse review is necessary under all levels of medication licensure. A registered nurse must visit the facility at least once every 30 days to monitor the medication regimen for all residents; evaluate the health states of residents; make necessary recommendations to the administrator; follow up on previous recommendations; and provide signed, written report in the facility documenting the visit.

Facilities offering care in special care units such as Alzheimer's Special Care Units must disclose information to the licensing agency and any person seeking placement in such a unit that explains the additional care that is provided by the unit including information on: the philosophy of care; pre-admission, admission, and discharge; assessment, care planning and implementation; staffing patterns and training ratios; physical environment: resident activities; family role in care; and program costs.

Financing

There is no Medicaid funding for assisted living services in Rhode Island at this time, but coverage is under consideration.

Medication

RNs must administer medications and monitor health conditions. Unlicensed staff may only remind residents to take their medications and observe. Staff must have four hours of training by an RN regarding policies and procedures and have passed an exam based on the training.

Staffing

Facilities must have a responsible adult on the premises at all times, in charge of the operation of the facility who is physically and mentally capable of communication with emergency personnel. Administrators must be at least 21 years old and obtain certification as a residential care/assisted living facility administrator or equivalent training. Certification requirements include at least 40 classroom hours of course work covering topics referenced in the regulations. The course work must take place in a college, vocational training, state or national certification program which is approved by the Director of Health. Licensed nursing home administrators are considered certified. Administrators must complete at least 16 hours of continuing education annually.

Monitoring

The licensing agency may inspect and investigate facilities as it deems necessary. Representatives of the licensing agency have the right to enter facilities any time without prior notice to inspect the premises and services. Every facility is given notice by the licensing agency of all deficiencies reported as a result of an inspection or investigation.

SOUTH CAROLINA

Category Community Residential Care Facilities **Model** Board and care

General approach

In 1996, Governor David Beasley issued a long term care plan for the state that created a framework for developing assisted living. The plan seeks to provide a continuum of care that is local and accessible. The plan recommends the exploration of long term care housing alternatives to expand the current array of choices and recognizes that nursing facilities and community residential care facilities will not continue to meet the diverse needs of aging and disabled citizens. "Assisted living has the potential to expand the current array of choices in the long term care service delivery system. Still in its early stages, assisted living may provide cost effective and appropriate services for frail elders and disabled adults. It offers developers, owners and management agencies prospects for expansion."

The state has established a task force which will make recommendations on assisted living. The task force includes representatives from the Department of Health & Human Services, Aging, Consumer Affairs and the Housing Finance and Development Authority. In addition, representatives from the residential care facilities association, two nursing home associations and others also participate. The task force expects to issue a report and recommendations in the fall of 1996.

Definition

"Community residential care facility is a facility which offers room and board and which provides a degree of personal assistance for a period of time in excess of twenty four consecutive hours for two or more persons, eighteen years old or older, unrelated to the operator within the third degree of consanguinity." The definition includes facilities which serve people with mental illness and alcohol or drug abuse needs.

Unit requirements

No more than four residents may share a room. One toilet is required for every eight residents and one tub/shower for every 10 residents. Pets are allowed.

Tenant policy

Facilities may not admit anyone suffering from acute mental illness, anyone

needing hospital or nursing home care, anyone needing daily attention of a licensed nurse.

Services

Facilities must provide personal assistance, protection and recreation. Personal assistance includes assistance with ADLS, assistance with making appointments and arranging transportation to receive supportive services required in the care plan. Continuous supervision must be provided for anyone whose mental condition is such that their safety requires it.

Medications

Facilities may administer medications and are responsible for ascertaining that medications are taken by residents in accordance with physician's orders.

Staffing

Administrators must be no less than 21 years of age, possess mature judgement and have sufficient education (high school or equivalent) to read, understand and comply with the regulations. At least one staff member shall be available for every ten residents during the day and one per 44 residents at night. Facilities with more than 10 residents must have one staff member awake and dressed at night.

SOUTH DAKOTA

Category Assisted Living Facilities Model Institutional

Definition

Assisted living center is defined as "any institution, rest home, boarding home, place, building, or agency which is maintained an operated to provide personal care and services which meet some need beyond basic provision of food, shelter, and laundry to five or more persons in a free standing, physically separated facility."

There are 65 facilities with about 1,200 beds in South Dakota.

Unit Requirements

In existing facilities each resident room must have at least 75 square feet of floor space per bed. In multi-bed rooms, each bed must be separated by a privacy curtain if requested by the resident. In newly constructed or renovated facilities, there must not be more than 2 residents per room. In single bed rooms, there must be a minimum area of 120 square feet and in two-bed rooms there must be at least 200 square feet. Each resident room must have a toilet room and lavatory.

Tenant Policy

Prior to admission, residents must submit written evidence from their physician of a physical examination certifying that they are in reasonable good health and free from communicable disease, chronic illness, or disability which requires any services beyond supervision, cuing, or limited hands-on physical assistance to carry out normal activities of daily living and instrumental activities of daily living.

Assisted living centers may not admit or retain residents who require ongoing nursing care. Facilities that admit or retain residents who require administration of medications must employ or contract with a licensed nurse who reviews resident care and condition at least weekly and a registered nurse or pharmacist who provides medication administration training to unlicensed assistive personnel who administer medications.

Facilities that admit or retain residents with cognitive impairments must have the resident's physician determine and document if services offered by the facility continue to enhance the functions in ADLs and identify if other disabilities and illnesses are impacting on the resident's cognitive and mental functioning. All staff

members must attend an annual in-service training in the care of the cognitively impaired and those with unique needs. Such facilities must have exit alarms.

Services

Medication administration, activities, and personal care services. "Outside services utilized by residents must comply with and complement facility care policies." Assisted living centers must provide for the availability of physician services. All residents must be seen by a physician at least once a year.

Financing

The SSI payment for room and board assisted living facilities is $877 per month less a personal needs allowance of $30. If the Department of Social Services determines that a Medicaid eligible individual also needs medication administration, the facility receives $150 per month through the Medicaid HCBS waiver for a total of $1,027 per month.

Staffing

The administrator must have a high school diploma or equivalent and, if hired after July 1, 1995, complete a training program and competency evaluation. For facilities with 10 or fewer beds, one staff person is permitted during sleeping hours. This staff person may sleep if the facility fire alarm is adequate to alert staff, a staff call system is available, the staff bedroom has an egress window, and the residents are capable of prompt evacuation. For facilities with 11 to 16 beds, one staff person who is awake is allowed during sleeping hours. The facility must have a formal orientation program and an ongoing education program for all personnel.

Monitoring

The governing body of the facility must provide for an ongoing evaluation of the quality of services provided to residents. Quality assurance evaluations must include the establishment of facility standards; interdisciplinary review of resident services to identify deviations from the standards and plans of correction; resident satisfaction surveys, utilization of services provided; and documentation of the evaluation.

TENNESSEE

Category	Home for the Aged	**Model**	Board and care
	Assisted care facility	**Model**	Not yet determined

General approach

A bill was signed April 24, 1996 that created an assisted care living facility category. Regulations will be developed by the Board for Licensure and Health Care Facilities. The Board has created a 13 member task force consisting of six members of the Board, three Department of Health representatives and four associations (Tennessee Health Care Association, Association of Homes for the Aging, Home Care Association and the Assisted Living Association). Once developed, the rules must be reviewed by the Attorney General. The rules are expected to be effective by the Spring of 1997.

There are 240 homes for the aged with 2,500 beds.

Definition

Assisted care living facility means a building, establishment, complex or distinct part thereof (1) which accepts primarily aged persons for domiciliary care and (2) which provides on site to its residents, room, board, non medical living assistance services appropriate to the residents' respective needs, and medical services as prescribed by each resident's treating physician subject to tenant admission and retention criteria.

Home for the aged: a home which accepts aged persons for relatively permanent, domiciliary care. It provides room, board and personal services to one or more non-related persons. A home for the aged may be any building, section or a building, or distinct part of a building, a residence, a private home a boarding home for the aged or other place, either for profit or not, which provides, for a period exceeding 24 hours, housing, food services and one or more personal services for one or more aged persons who are not related to the owner or administrator by-blood or marriage. Homes for the aged must have agreements with a physician who is available to render care or who will come to the home to visit residents when necessary and with a nursing home that will accept its residents who must be discharged.

Unit requirements

Assisted care living facility. Not specified in the law.

Home for the aged. Each resident must have at least 80 square feet of bedroom space. Bedrooms may not have more than two beds, and privacy screens or curtains must be provided and used when requested by the resident. Beds with full side rails, potty chairs, bedpans, or urinals shall not be used routinely in residents' rooms. Residents' rooms must always be capable of being unlocked by the resident.

Tenant policy

Assisted care living facility. Residents must be ambulatory. People may not be admitted who have late stage Alzheimer's Disease, require physical or chemical restraints, pose a serious threat to self or others, require nasopharyngeal and tracheotomy aspiration, require a regimen involving administration of medical gasses, require arterial blood gas monitoring or are not able to communicate his or her needs.

Assisted care living facilities may retain for 21 days but not admit anyone requiring intravenous or daily intramuscular injections of feedings, require gastronomy feedings, insertion, sterile irrigation and replacement of catheters, sterile wound care, or treatment of extensive stage 3 or 4 decubitus ulcers or exfoliative dermatitis, or who, after 21 days, require four or more skilled nursing visits per week for any other condition.

Home for the aged. Residents who need continual professional medical/nursing observation and/or care cannot be admitted or retained. Residents who require more technical nursing care or medical care than the personnel and the facility can lawfully provide shall be transferred to a hospital or nursing home. Homes for the aged cannot admit a person whose primary diagnosis is a mental health condition which clearly endangers himself or others and/or who is receiving active treatment from a mental health facility for a condition which clearly endangers himself and others. Homes for the aged may serve people with mental health conditions, but these residents may not make up more than 50% of the home's residents. Persons in the early stages of Alzheimer's and related disorders may be admitted if an interdisciplinary team made up of a physician who is experienced in the treatment of Alzheimer's disease, a social worker, registered nurse, and a family member (or patient care advocate) determines that care can appropriately and safely be given in the home for the aged. Such residents must be reviewed at least quarterly as to the appropriateness of placement in the home.

Services

Assisted care living facility. Non-medical living assistance and some medical services may be provided. Medical services include part time or intermittent nursing,

physical, occupational and speech therapy, medical social services, medical supplies, durable medical equipment may be provided but only by a licensed home care agency. Home health aide services may not be provided by a licensed home care agency because they would duplicate services provided by the facility.

Home for the aged. Assistance and supervision with medications; medications may be administered by a licensed nurse. Homes for the aged may not care for residents who require restraint, and so must not use restraints. Homes may provide personal care such as bathing, dressing, and grooming of hair, fingernails and toenails. Laundry and linen services are also provided. Food service and recreational activities are also provided.

Financing

Assisted care living facilities. The law does not authorize Medicaid coverage for medically necessary home care services provided in an assisted care living facility.

Home for the aged. Personal care is not funded by Medicaid either as a state plan service or as a waiver service. There is an SSI pilot program paying up to $9/day/quarter per resident, with an overall spending cap of $525,100.

Medications

Assisted care living facility staff may assist with self-administration of medications.

Staffing

The licensee of a home for the aged must be at least 18 years old. The chief administrator of the home must be certified by the Board as a residential home administrator, unless the administrator is currently licensed in Tennessee as a nursing home administrator. The licensee must have a high school diploma or equivalent; persons serving as a chief administrator of a licensed home for a continuous period of at least 9 months prior to Jan. 1 1990 are exempt from this requirement. Licensees must have at least 24 hours of continuing education each year. Personal care attendants must be at least 18 years old. Facilities with 5 or more residents whose level of evacuation capability is classified as “slow” must have a responsible attendant on duty and awake at all times.

inspections are conducted each year. Deficiencies must be addressed by plans of correction. Homes must comply with local fire safety authority regulations.

TEXAS

Category	Personal care homes Assisted living (Medicaid)	**Model**	Board and care Multiple settings

General approach

A work group formed by the Texas Commission on Human Services began meeting in February 1996 to consider an assisted living licensure category or changes in existing categories. The group issued recommendations in September that revise the regulations for personal care homes but do not create a separate licensure category for assisted living. The major issues in considering a separate category were the level of care that can be provided and requirements for administration of medication. Nursing home members have opposed broadening the level of care than can be provided outside a nursing facility. The average occupancy rates among for-profit nursing facilities in Texas is 80-83%.

The existing licensure category covers personal care homes. Assisted living/residential care services are provided through the state's Medicaid Home and Community Based Services waiver program in licensed personal care homes. Settings must be licensed as personal care homes and may contract with Medicaid under three models: assisted living apartments, residential care apartments and residential care non-apartments.

The Texas Medicaid program contracts with 120 facilities to provide assisted living/residential care services. The state has federal approval to serve 22,000 people through its Medicaid HCBS waiver. The state has funding for 16,000 slots. Ninety two percent of the participants live in their own single family homes or apartments, 4% (640) live in assisted living facilities and 4% reside in adult foster care sites.

Definition

Assisted living/residential care services provide a 24 hour living arrangement for persons who, because of a physical or mental limitation, are unable to continue independent functioning in their homes. Services are provided in personal care facilities licensed by the Texas Department of Human Services (DHS). In effect the rules recognize 3 types of units provided in licensed personal care facilities. Nursing facility waiver participants are responsible for their room and board costs and, if applicable, a copayment for assisted living/residential care services.

The regulations define personal care homes as "an establishment, including a

board and care home, that furnishes food and shelter in one or more facilities to four or more persons who are unrelated to the owner of the establishment; provides personal care services; and in addition, provides minor treatment under the direction and supervision of a physician . . . or services which meet some need beyond basic provisions of food, shelter and laundry."

Unit requirements

The Medicaid program guidelines distinguish among assisted living apartments, residential care apartments and residential care non-apartments. Assisted living apartments must provide each participant a separate living unit to guarantee their privacy, dignity and independence. Units must include individual living and sleeping areas, a kitchen, bathroom and adequate storage. Units must provide 220 square feet, excluding bath, but units in remodeled buildings may provide 160 square feet. Double occupancy units may be provided if requested.

Residential care apartments must be double occupancy with a connected bedroom, kitchen, and bathroom area providing a minimum of 350 square per client. Indoor common space used by residents may be counted in the square footage requirement. Kitchens must be equipped with a sink, refrigerator, cooking appliance (stove, microwave, built-in surface unit) that can be removed or disconnected and space for food preparation.

Residential care non-apartments means a licensed personal care facility which does not meet either of the above definitions. These units may be double occupancy units in free standing buildings that have 16 or fewer beds.

The personal care homes rules require 80 square feet for single bedrooms and 60 square feet per bed for multiple occupancy rooms in Type A facilities and 100 square feet and 80 square feet respectively in Type B facilities. A maximum of four people may share a room. Unit with separate living/dining and bedroom space may include 10% of the required bedroom space as the living area.

Tenant policy

The personal care home rules allow facilities to serve residents who have mental or emotional disturbance but are not a danger, need assistance with movement, bathing, dressing, and grooming, routine skin care (such as application of lotions, treatment of minor cuts and burns), need reminders to encourage toileting, require temporary services by professional personnel, need assistance with medications, supervision of self-medication or administration of medications, have

hearing or speech impairments, are incontinent but without pressure sores or need assistance with meals.

Facilities may not admit or retain residents whose needs cannot be met by the facility and residents requiring services from the facility's RN on a daily or regular basis (exceptions for residents with terminal conditions or needing services for a short term).

Three types of Personal Care Homes are licensed. Type A home residents are capable of evacuating the facility unassisted, do not require attendance during night time hours and are capable of following directions under emergency conditions. Type B facility residents may require staff assistance to evacuate, may not be able to follow directions, require attendance during the night and while not permanently bedfast, may require assistance in transferring to and from a wheelchair. Type C facilities offer four beds and are considered adult foster care but after the effective date of the regulations, will be required to obtain a personal care license.

Services

Services that can be provided through the waiver include 24 hour supervision, personal care, administration of medications, congregate meals and social and recreational activities. Nursing services must be provided through contracts with certified home health agencies.

The proposed personal care homes rules would allow licensed staff to administer medications and provide occasional treatment which enables residents to maintain independence. Residents may contract to have home health services provided. The rules broaden the definition of personal care to include the administration or assistance with or supervision of medication to implement changes that allow nurse delegation under the nurse practice act.

Financing

The Medicaid waiver provides $35.06 a day for services in single occupancy assisted living apartments, $27.76 a day for double occupancy residential care apartments and $22.63 a day for residential care non-apartments. The SSI payment for room and board is $370 a month. The combined room and board and service rates are $1,450.68 a month for assisted living apartments, $1,225.11 for residential care apartments and $1,072.81 for residential care non-apartments. The waiver includes a cap that limits community based alternatives services to no more than 95% of rate paid to nursing homes.

Medications

The waiver rules allow the direct administration of all medications or assistance with or supervision of medication. The proposed changes in personal care home rules allow unlicensed staff to administer medications as well as to assist with or supervise medications through nurse delegation provisions.

Staffing

Managers must have a high school diploma or equivalency and 12 hours of annual continuing education in designated subject areas. Attendants providing personal care must have knowledge of resident needs, tasks to be provided, health conditions and related conditions. Required staff ratios are 1 to 16 for day shifts; 1 to 20 for evening shifts and 1 to 40 for night shifts. RNs, aides or medication aides must receive annual in-service training from a number of specified areas.

UTAH

Category Assisted living **Model** Multiple settings

General Approach

The state's regulations were effective July 1995 and establish assisted living as a place of residence where elderly and disabled persons can receive 24 hour individualized personal and health related services to help maintain maximum independence, choice, dignity, privacy, and individuality in a home-like environment. The rules provide for three levels of license: large facilities, 14 or more residents; small facilities, 6-13 residents; and limited capacity facilities, up to five residents.

By July 1996, three facilities comprising 74 units had been licensed and applications for 6 facilities were pending. Two applications have been filed by residential health care facilities seeking to convert to assisted living. No significant issues have emerged as a consequence of the regulations.

State agencies are developing a capitated long term care demonstration that would include assisted living as a covered service.

Definition

HB 201, which was passed during the 1994 legislative session, defines assisted living as "a residential facility with a home-like setting that provides an array of coordinated supportive personal and health care services, available 24 hours per day, to residents who have been assessed under division rule to need any of these services. Each resident shall have a service plan based on the assessment, which may include: specified services of intermittent nursing care, administration of medication, and supportive services promoting residents' independence and self-sufficiency."

Unit requirements

A residential living unit means a one or two bedroom unit which may also include a bathroom and additional living space. A maximum of two residents may occupy a resident living unit and only by the consent of the residents. Additional living space means a living room, dining space and kitchen facilities, or a combination of these facilities, in a resident living unit. Units must have lockable doors and tenants must have a key.

Facilities providing only bedrooms must provide a toilet and lavatory for every four residents and a bathtub or shower for every ten residents. Occupancy units without additional living space must be a minimum of 120 square feet for single occupancy units and 200 square feet for double occupancy units. Bedrooms in units that do provide additional living space must be at least 100 square feet for single units and 160 square feet for double units.

Tenant policy

Facilities may not serve anyone who requires inpatient hospital care or 24 hour continual nursing care that will last more than 15 calendar days or people who cannot evacuate without physical assistance of one person. Written acceptance, retention and transfer policies are required of each facility. Facilities may not accept anyone who is suicidal, assaultive or a danger to self or others, has active tuberculosis or other communicable disease that cannot be adequately treated at the facility or on an outpatient basis or may be transmitted to other residents through general daily living.

A physician's statement is required that documents the resident's ability to function in the facility and describing the following information: whether the resident's health condition is stable, free from communicable disease, allergies, diets, current prescribed medications with dose, route, time of administration and assistance required, physical or mental limitations and activity restrictions.

The rules allow pets to be kept if permitted by local ordinances.

Services

Facilities must provide personal care, food service, housekeeping, laundry, maintenance, activity programs, medication administration and assistance with self-administration and arrange for necessary medical and dental care. The rules allow facilities to provide skilled nursing services and therapies.

Financing

The state had anticipated amending its HCBS waiver to add assisted living as a covered service, however, officials have had difficulty developing rates that current licensed providers would accept. Further work is being done. In addition, a task force developing a capitated long term care demonstration program plans to include assisted living as a service covered by the capitation payment.

Medications

Facilities are allowed to provide medication administration by licensed staff and assistance with self-medication by unlicensed staff (opening containers, reading instructions, checking dosage against the label, reassuring the resident that the correct dosage was taken and reminding residents that a prescription needs to be refilled.

Staffing

Direct care staff are required on-site 24 hours a day to meet resident needs as determined by assessments and service plans.

Board and care

Residential health care facilities are not allowed to provide nursing services and therapies although residents may contract on their own with a community home health agency to receive these services. RHC residents must be ambulatory and able to evacuate in an emergency. Assisted living residents may be semi-independent or require assistance from one person to transfer or ambulate.

VERMONT

Category	Residential care homes (Level III, IV) Assisted living (task force)	**Model**	Board and care Multiple settings

General approach

The Department for Aging and Disability has established a task force that is developing an assisted living model. The task force is focusing on elders and adults with disabilities and is likely to cover purpose built facilities and HUD elderly housing sites. Both Medicaid and state funded homemaker and/or attendant care programs are being considered for financing services for low income residents. The task force is expected to recommend that assisted living units will be apartment units. Facilities offering private rooms with attached baths and access to a kitchen prior to the new policy will be grandfathered.

In 1995, the Vermont legislature approved funding for a pilot project to provide residential services to Medicaid recipients. The Department of Aging and Disabilities received approval from HCFA on March 1, 1996 for a Medicaid Home and Community Based Services Waiver to offer "enhanced residential care" to residents in Level III Residential Care Homes. The program reflects several aspects of state assisted living programs. The goals of the program are to "provide the availability of a wide range of appropriates services for older persons and persons with disabilities in a shared, home-like environment; to promote the principles of choice, individuality, dignity, privacy and decision making ability of the participant in a manner which fosters the maximization of her/his abilities and independence in the least restrictive setting; and to reduce and prevent unnecessary institutional care." The initiative responds to the increased acuity of people in residential care homes.

The program standards include negotiated risk which is defined as "allowing residents choices in accepting certain risks. These choices are negotiated between the resident, case manager, provider, and family members with the intent of fostering independence, safety and self-determination.

The services include nursing overview (assessment, oversight, monitoring and routine tasks), personal care services, case management, medication assistance, recreational and social activities, support for individuals with cognitive impairments and 24 hour on-site supervision. The waiver allows up to 200 participants although funding is available for 70 participants a month and 98 unduplicated participants during the first year. Services must be provided in non-institutional, home-like settings. Participants must meet the nursing home eligibility criteria. While not required,

preference is given to providers that offer single occupancy units.

The project established four outcome measures: participants are satisfied with Enhanced Residential Care Services; participants continue to reside in his/her residence of choice; participants receive all services which are necessary to live as independently as possible; and services provided are comprehensive and individualized.

A 1994 survey of residential care home residents conducted by the Department of Aging and Disabilities found that the median age was 81, 53% are private pay (47% SSI) and over half of all residents have a diagnosis of mental illness, mental retardation or dementia. Fifty seven percent of the residents had no functional impairments. Residents were less impaired than nursing home residents. There were 157 licensed homes caring for 1812 residents.

Definition

Residential care home is a place, however named, excluding a licensed foster home, which provides for profit or otherwise, room, board and personal care to three or more residents unrelated to the licensee. Level III means a residential care home licensed to provide room, board, personal care, general supervision, medication management and nursing overview. Level IV homes do not provide nursing overview.

Unit requirements

The regulations indicate that every effort must be made to provide a home-like environment. Each private bedroom must have at least 100 square feet of usable floor space and multi-bed rooms must have 80 square feet per bed. After October 1993, all new homes may offer only single or double occupancy rooms. One bath, toilet and sink is required for every eight residents.

Tenant policy

Facilities must provide a written agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services covered in the rate and the concerning discharge or transfer when a resident's financial status changes from private pay to SSI.

Residential care homes may retain people who need nursing services if the following conditions are met:

- The services are received less than three times a week; are provided seven days a week for no more than 60 days and the resident's condition is improving;

- The home has an RN on staff or a contract with a home health agency;

- The home is able to meet the resident's needs without detracting from services to other residents;

- There is a written agreement concerning which nursing services the home provides or arranges which is explained to the resident before admission or at the time of admission, how services are paid for and the circumstances under which a resident will be required to move;

- Residents are fully informed of their options and agree to such care in the residential home.

RCHs cannot admit or retain anyone needing full time nursing care, the level of care provided in a nursing facility, or who has care needs which exceed the facility's capacity to safely and appropriately provide. Residents who have a serious, acute illness requiring medical, surgical or nursing care cannot be admitted or retained.

Services

RCHs provide personal care, medication management, laundry, meals, toiletries, transportation and nursing overview. Nursing overview means a process in which a nurse assures that the health and psychosocial needs of the resident are met. The process includes: observation, assessment, goal setting, education of staff and the development, implementation and evaluation of a written individualized treatment plan to maintain the resident's well being.

Intravenous therapy, ventilators or respirators, daily catheter irrigation, feeding tubes, care of stage III or IV decubitus, suctioning and sterile dressings may not be provided to any resident unless a variance is approved by the state licensing agency.

Medication

RCH staff are able to assist resident to self-administer medications and administer medication under the supervision of and delegation by registered nurses.

Reimbursement

Two levels of SSI reimbursement are provided based on the provision of nursing oversight.

Monitoring

Monitoring is conducted by the licensing agency and the ombudsman program.

Fees

Fees are $5 plus $1 per bed.

VIRGINIA

Category Adult care residence **Model** Board and care

General Approach

The state legislature has created a two-tier licensing structure for adult care residences, residential and assisted living. Regulations were effective February 1, 1996. A Medicaid HCBS waiver was effective August 1, 1996. The regulations contain a statement of philosophy and guiding principles. The regulations are intended to maximize independence and promote the principles of individuality, personal dignity, freedom of choice, and fairness for all individuals residing in adult care residences. The principles state that:

- Residents are entitled to appropriate, safe and quality care;
- Each resident shall be viewed as an individual and empowered to make decisions regarding his care;
- Each residence should identify the types and extent of services offered and those services should reflect the needs of the population served;
- The resident should be entitled to remain in care as long as the facility is able to adequately care for the resident within the limitations established by law so that social ties and relationships may be preserved to the fullest extent possible;
- Standards are consistent with the provision of cost effective services.

Definition

Adult care residence (ACR) means any place, establishment, or institution, public or private, operated or maintained for the maintenance or care of four or more adults who are aged, infirm or disabled and who are cared for in a primarily residential setting, except a facility or portion of a facility licensed by the State Board of Health or the Department of Mental Health, Mental Retardation and Substance Abuse (and other exceptions).

Residential living means a level of service provided by an adult care residence for adults who may have physical or mental impairments and require only minimal assistance with activities of daily living. Minimal assistance means dependency in only

one ADL or one or more IADLs or medication administration.

Assisted living means a level of service provided by an adult care residence for adults who may have physical or mental impairments and require at least moderate assistance with activities of daily living. Moderate level of assistance means dependency in two or more ADLs. This level also includes individuals who are dependent in behavior pattern (abusive, aggressive, disruptive). Within assisted living, there are two payment levels for recipients of an Auxiliary Grant: regular assisted living and intensive assisted living as defined by the Department of Medical Assistance Services. Intensive assisted living services are for individuals who meet the criteria for home and community based waiver services (at risk of nursing home placement).

Unit requirements

The regulations change the unit requirements for newer buildings. ACRs may offer single rooms (minimum 100 square feet for newer buildings) or multiple occupancy rooms (80 square feet per occupant). A maximum of four people may occupy a room. Facilities must provide one toilet and wash basin for every seven people and one bath tub for every ten people.

Tenant policy

ACRs cannot admit or retain residents with the following conditions or needs:

- Ventilator dependent.
- Dermal ulcers (Ill or IV) unless a stage III ulcer is healing.
- intravenous therapy or injections directly into the vein.
- Airborne infectious disease in a communicable state.
- Psychotropic medications without an appropriate diagnosis and treatment plan.
- *Nasogastric tubes.
- *Gastric tubes except when an individual is capable of independently feeding himself and caring for the tube or by exception.
- Individuals who present a danger to themselves or others.
- Individuals requiring continuous nursing care (around the clock observation, assessment, monitoring, supervision, or provision of medical treatment by a licensed nurse).
- Individuals whose physician certifies that placement is no longer appropriate.
- Unless the individual's physician determines otherwise, individuals who require maximum physical assistance as documented by an assessment

and meet Medicaid nursing facility level of care criteria.

- Individuals whose health care needs cannot be met in the specific ACR as determined by the residence.

* Exceptions are allowed when requested by resident and care is provided by a physician, a licensed nurse or a certified home health agency except for Auxiliary Grant residents.

Public pay residents must have an assessment completed by a case manager or other qualified assessor. Assessments for private pay residents may be completed by a case manager or other qualified assessor, an independent private physician, or an employee of the facility who has documented training in the completion of the uniform assessment instrument. Assessment completed by facility staff must be signed by the administrator or designated representative.

Services

The regulations offer ACRs the flexibility to develop a program and service plan that meets the following criteria:

- Meet physical, mental, emotional and psycho-social needs,
- Provide protection, guidance and supervision;
- Promote a sense of security and self worth; and
- Meet the objectives of the service plan.

Each facility develops a written program description for prospective residents that describes the population to be served and the program components and services available. Facilities are permitted but are not required to offer all services as long as they have services that are appropriate for the needs of residents.

The Medicaid payment for intensive assisted living services covers personal care, homemaker, attendant care, companion services, medication oversight and therapeutic social and recreational programming. ACRs must also provide 24 hour capacity to meet scheduled and unscheduled service needs. Skilled nursing services provided by a certified home health agency for less than 30 days may be delivered. Eleven hours of activities per week for residential living and fourteen hours for assisted living must be scheduled.

An assessment using the approved Uniform Assessment Instrument must be performed on all residents prior to admission, every 12 months, and whenever a change in the resident's condition warrants a level of care change. An individualized

service plan or plan of care is developed from the assessment in conjunction with the resident, family, case worker, case manager and health care providers..The service plan shall reflect the philosophy and values described above.

Financing

Two payment levels for the provision of personal care services in ACRs with an assisted living license have been developed to supplement the ACR's Auxiliary Grant rate which covers room, board, basic supportive services and supervision. The Auxiliary Grant program is a state and locally funded assistance program to supplement the income of a recipients of the federal Supplemental Security Income (SSI) program and certain other aged, blind and disabled individuals residing in an ACR. The maximum Auxiliary Grant payment is $695 or $799 depending upon the area of the state. DMAS provides an additional per diem payment above the current auxiliary grant rate for regular assisted living services, which are reimbursed by General Funds rather than Medicaid at a rate of $3 a day to a maximum of $90 a month; and the rate for intensive assisted living services, which is a combination of general funds and federal waiver funds, is $6 a day and a maximum of $180 a month. Nursing care would not be covered in the rate.

Medications

Self-administration of medications is allowed, although assistance with self-administration is not described in the regulations. Medication administration is permitted when licensed staff are available or a medication training program approved by the Board of Nursing has been completed.

Staffing

Staffing patterns must be appropriate to deliver the services required by the residents as described in the plans of care.

Monitoring

Public pay receive annual reassessments by assigned case managers. Residents who require coordination of multiple services, are not able and do not have support available to assist in coordinating activities and need **a level of coordination** that is beyond what the ACR is able to provide receive Medicaid funded, targeted case management from a case manager.

Private pay residents also receive annual reassessment to assure continued

appropriate placement.

The Department of Social Services conducts regular licensing inspections of ACRs. DMAS conducts on-site visits to monitor the quality and appropriateness of assisted living services provided to public pay residents of ACRs.

WASHINGTON

Category	Boarding homes Assisted living (Medicaid)	**Model** **Model**	Board and care Housing and service

General Approach

The state initiated its assisted living program as a pilot program under Medicaid in one site in 1989. Effective June 8, 1996, the Aging and Adult Services Administration issued regulations for licensed boarding homes who contract with Medicaid for residential care services that covered assisted living, enhanced adult residential care and adult residential care. Boarding homes are licensed by the Health Department.

The number of facilities contracting with Medicaid has risen from 14 representing 1200 units in January 1995 to 77 and approximately 3800 units in September 1996. 847 units were occupied by Medicaid clients in July 1996.

During the initial years of the program, the Aging and Adult Services Administration budget contained assumptions about the number of recipients that would be placed in assisted living. However, there is no limit and the most recent budget transferred funding for 1600 nursing homes beds to allow AASA to divert residents to HCBS and residential services. Contracting for new units for Medicaid recipients requires adding capacity through new construction or contracting with existing facilities whose availability varies with resident turnover rates. State policy limits the percentage of units that they will contract for in a facility.

Definition

"Assisted living services is a package of services, including personal care and limited nursing services, that the department contracts with a licensed boarding home to provide in accordance with Parts I and II of this chapter. Assisted living services include housing for the residents in a private apartment-like unit."

The contract previously defined assisted living as "a coordinated array of personal care, health services and other supportive services available 24 hours per day to residents who have been assessed to need these services. Assisted living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, choice and residential surroundings."

Unit requirements

New facilities with assisted living Medicaid contracts must provide individual units with 220 square feet including counters, closets and built-ins, and excluding the bathroom. Existing facilities may have a minimum of 180 square feet. The kitchen area must have a refrigerator, microwave or stove stop and a counter or table for food preparation. New facilities must also have a sink and counter area and storage area. Units must have lockable entry doors and a living area wired for telephone and television service, where available. The physical environment is supposed to enhance autonomy in ways which reflect the personal and social values of dignity, privacy, independence, individuality, choice and decision-making of residents. Facilities must provide a home-like environment enhancing the dignity, independence, individuality, privacy, choice and decision-making ability of residents.

Two people may occupy a unit but only by choice. Facilities are prohibited from offering a shared unit at a lower cost per month. Medicaid will reimburse facilities a separate full rate for a qualified second occupant.

The boarding home rules allow two people to share a room (four if licensed prior to July 1989) and rooms must provide 80 square feet for single rooms and 70 square feet per resident for multiple occupancy. One sink is required for every eight residents and bathing facilities for every 12 residents.

Tenant policy

Residents may be required to move when their needs exceed the services provided through the contract with the state agency; the residents places themselves or others at an unreasonable risk; the residents have failed to make proper payments for services; or the residents require a level of nursing care that exceeds what is allowed by the boarding home license. Case managers must approve all discharges from facilities.

Services

The service package includes personal care, nursing services, social services, consultation (dietician, pharmacist), social/recreational activities, 3 meals, housekeeping and laundry. Nursing services are differentiated by licensure category. RNs or LPNs may provide insertion of catheters, nursing assessments, and glucometer readings. Unlicensed staff may provide the following under supervision of an RN or LPN: stage one skin care, routine ostomy care, enema, catheter care, and wound care. Unlicensed staff may provide assistance with transfer, mobility, hygiene

and incontinence.

The negotiated service plan format has been changed. A specified form is no longer required. A formal written negotiated plan, which involves the resident, appropriate staff, AASA case manager and family or others if chosen by the residents, must be completed within 30 days of move-in. The services must meet a range of needs and preferences of residents and facilitate aging in place by being flexible. Services must support managed risk and allow the resident to take responsibility for risks associated with decision-making.

The service plan should decrease the probability of a poor outcome when a resident's decision or preference places the resident or others at risk, leads to adverse consequences, or conflicts with other residents' rights or preferences. This negotiated services planning process is now required for boarding homes and adult family care programs.

Facilities must provide personal care services based on the resident's negotiated service agreement and provide the range of services required to meet the increasing or changing needs of residents as they age-in-place to the maximum extent permitted by boarding home regulations. Contractors have to provide or arrange for limited nursing services at no additional cost.

Facilities must also assist the resident to arrange, obtain and coordinate services such as transportation to medical appointments and recreational activities, ancillary services related to medical care (physician, pharmacist, mental health, physical or occupational therapy, hospice, home health care, podiatry), barber/beauty services and others necessary to support and assist the resident in maintaining independence.

Services allowed in boarding homes are similar to those allowed in boarding homes contracting as assisted living.

In 1995, amendments to the state's nurse practice act were passed which allow RNs to delegate tasks to nursing assistants in licensed boarding homes, assisted living facilities and adult family homes. Nursing assistants must complete a core training program. Nurses may delegate the following tasks: oral and topical medications and ointments; nose, ear, eye drops and ointments; dressing changes and catheterization; suppositories, enemas and ostomy care; blood glucose monitoring and gastronomy feeding in established and healed condition. Delegation is at the discretion of the nurse and only for people whose conditions are stable and predictable.

Financing

The reimbursement methodology and rate for Medicaid recipients who meet the nursing home level of care criteria has been revised. AASA developed three rate levels and three geographic areas. The rates are based on components for nursing staff, operations and capital costs. Residents without any other income apply $14.79 per day from their SSI check to the room and board costs. Services costs are reimbursed by Medicaid. See narrative for a discussion of the rate structure.

Washington Rate Structure			
	Level 1	**Level 2**	**Level 3**
MSA Counties	$51.36	$57.05	$63.29
Non-MSA counties	$49.93	$55.39	$61.05
King County	$55.74	$66.32	$69.41

A capital add-on is available for newly constructed facilities whose capital costs exceed the allowance. The add-on ranges from $4.08 to $4.49.

Medications

Medication administration is covered under the boarding homes rules. The boarding home rules allow for reminders, assistance with self-administration and administration of medications by licensed staff. Changes in the nurse practice act to allow nurse delegation is pending in the legislature.

Staffing

RNs or LPNs are required to be available on-site 5 hours a day, 7 days a week and on call 24 hours a day to provide services listed in the negotiated service agreements. Other staff must be sufficient to deliver services identified in service agreements. New staff must receive five hours of training and monthly in-service sessions on assisted living values and principles.

Monitoring

Case managers are a primary source of monitoring for quality assurance. During regular visits, the case manager checks to see if the client is satisfied, the

negotiated service plan is being carried out and that the plan is appropriate for the resident.

Fee

Facilities are charged $34 per licensed bed. An additional $150 is payable for facilities receiving a third site visit because of failure to respond adequately to deficiencies or a complete on-site review resulting from a complaint.

WEST VIRGINIA

Category		Model	
	Personal Care Homes		Board and care
	Residential Care Homes		Board and care

Definition

Nursing and personal care homes: “Any institution, residence or place or any part or unit thereof, however named, in this state which is advertised, offered, maintained or operated by the ownership or management, whether for a consideration or not, for the express or implied purpose of providing accommodations and personal assistance and supervision, for a period of more than twenty-four hours, to more than 10 persons who are dependent upon the services of others by reason of physical or mental impairment who may require limited and intermittent nursing care, including those individuals who qualify for and are receiving services coordinated by a licensed hospice.”

Board and Care Homes: “Any residence or any part or unit thereof, however named, in this state which is advertised, offered, maintained or operated by the ownership or management, whether for a consideration or not, for the express or implied purpose of providing accommodations and personal assistance and supervision, for a period of more than twenty-four hours, to four (4) to ten (10) persons who are not related to the owner or managed by blood or marriage with in the degree of consanguinity of second cousin and are dependent upon the services of others by reason of physical or mental impairment or who may require limited and intermittent nursing care but are capable of self-preservation and are not bedfast, including those individuals who qualify for and are receiving services coordinated by a licensed hospice.”

There are 71 licensed personal care homes and 88 residential board and care homes.

Unit requirements

Single rooms must have at least 80 square feet of floor space, and rooms with multiple beds must have at least 60 square feet per resident. There may not be more than three residents per bedroom. Each resident must have access to a toilet and washroom without entering another bedroom. There must be at least one toilet and washroom per 6 people, including staff. There must be at least one bathing facility per 10 individuals residing in the home, and at least one per floor on which the resident rooms are located.

Tenant policy

Residents must be capable of self-preservation on admission and may need personal assistance in activities of daily living, supervision because of mental or physical impairment, or have limited and intermittent nursing care needs. Individuals with identified mental or developmental disabilities may be admitted if the home can provide evidence of continued professional follow-up to address the individual's mental health needs or the individual is a client of licensed behavioral health agency.

Facilities may not admit those who require the use of routine physical or chemical restraints, require ongoing or extensive nursing services, or require a level of service of which the home is not licensed or does not provide. Individuals who become bedfast subsequent to admission may remain in the home for 90 days during a temporary illness or recovery from surgery if the resident's care does not require nursing care in excess of limited and intermittent nursing care.

Services

"The home shall provide treatment and care in accordance with the functional needs assessment and service plan to assist each resident to maintain the highest level of functioning possible." Services include making appointments for appropriate medical, dental, nursing or mental health services as needed by the resident; arranging for transportation; personal assistance; assistance with medication administration; supervision.

Financing

The state does not currently reimburse residential care homes but is exploring a method to do so.

Staffing

The administrator must be at least 21 years old and have a high school diploma or GED. The administrator must participate in 10 hours of training annually. There must be at least one staff in the facility at all times. There must be awake staff during normal resident sleeping hours when residents require supervision during sleeping hours or are in need of limited and intermittent nursing services. Training shall be provided to new employees and admissions within the first 24 hours of association with the home in emergency procedures and disaster plans. Other training in policies and procedures of the home and the care of residents must be completed within 15 days of employment.

Monitoring

On-site unannounced inspections as needed and complaint investigation.

WISCONSIN

Category Assisted living **Model** **New** housing and services

General Approach

Regulations providing for registration and certification of assisted living facilities are pending. The following descriptions are based on the pending regulations, Registered facilities submit an application and may be visited by the department staff to determine compliance. Tenants must be notified that the department does not regularly visit or inspect registered facilities. Facilities who seek to receive Medicaid reimbursement must be certified. On-site review of applications may be conducted. Facilities must submit documents showing compliance with all applicable federal, state and local licensing, building, zoning and related requirements. The department conducts periodic inspections of certified facilities.

An Assisted Living Advisory Committee developed a draft report in 1994 which was the basis of a legislative proposal. The legislature amended and passed a proposal submitted by the governor as part of the budget to permit development of assisted living facilities in the state. The legislation provides for the certification of assisted living facilities under rules developed by the Department of Health and Social Services. The proposed rules were subject to public hearings during 1996 and were submitted to the House and Senate for approval on May 29, 1996.

The draft report emphasized a philosophy that is the basis of the long term care system called RESPECT (relationships, empowerment to make choice, services to meet individual needs, physical and mental health services, enhancement of participant reputation, community and family participation and tools for independence).

Definition

The draft rules define assisted living as “a place where five or more adults reside that consists of independent apartments, each of which has an individual lockable entrance and exit, a separate kitchen, including a stove, and individual bathroom, sleeping and living areas, and that provides, to a person who resides in the place, not more than 28 hours per week of services that are supportive, personal and nursing services. Assisted living facility does not include a nursing home or a community-based residential facility, but may be physically part of a structure that is a nursing home or community based residential facility.”

Unit requirements

The draft rules require units with a minimum of 250 square feet for sleeping and living areas, not including the kitchen, bathroom, closets and cabinetry. A minimum of 350 square feet may be provided for sleeping, living and kitchen space, not including the bathroom. The kitchen must be a visually and functionally distinct area of the unit. The sleeping and living area also has to be visually and functionally distinct but not separate room.

Tenant policy

The legislation requires the development of a mutually agreed upon service agreement and signing of a negotiated risk agreement. The risk agreement identifies situations or conditions known by the facility to arise from the tenant's preferences which are contrary to the facility's advice, the tenant's preferences, how they will be accommodated, alternatives offered to reduce the risk, the agreed upon course of action and the tenant's understanding and acceptance of responsibility.

Facilities could not admit anyone who has a court determination of incompetence, anyone who has an activated power of attorney for health care, anyone found by a physician or psychologist to be incapable of recognizing danger, summoning assistance, expressing need or making care decisions. Facilities may retain tenants whose needs can be met by the facility or met by services available from another provider. Facilities may also retain a tenant who becomes incompetent as long as their is adequate oversight and the service and risk agreements are signed by the guardian or agent with power of attorney.

Facilities may terminate agreements with tenants whose needs cannot be met by the required level of service, service needs exceed 28 hours a week (unless additional services are secured by the tenant from other providers), tenants require 24 hour a day nurse availability, the tenant is a danger to self or others or fees have not been paid.

State funding would be provided to Medicaid recipients who meet the nursing home level of care criteria through the Medicaid Community Options Program Waiver (COP-W) and the Community Integration Program (CIP). CIP funding is only available when nursing home beds are closed and funding is transferred to provide community care to replace the closed capacity. The legislation addresses the type of resident who may be served through the 28 hour per week cap on services. Tenants needing more care could not be supported in assisted living. The regulations that will be developed may address the types of residents who may be served as opposed to the amount of

reimbursement that will be provided for Medicaid tenants.

Services

A comprehensive assessment would be completed and used as the basis for completing the service plan and the risk agreement. The assessment would cover: physical health, physical and functional limitations and capacities, medication and ability to self-administer, nutritional status and needs, mental and emotional health, behavior patterns, social and leisure needs and preferences, strengths, abilities and capacity for self-care, situations or conditions which could put the tenant at risk, and the type, amount and timing of services desired by the tenant.

The minimum required services include supportive services, personal services and nursing services. Supportive services include meals, housekeeping in the resident's apartment, laundry and arranging access to medical care. Personal services include assistance with ADLs. Nursing services include health monitoring, medication administration and medication management.

The budget legislation sets a limit of 28 hours a week for supportive nursing and personal care services. The advisory committee concluded that assisted living residents may require more care than people in the community and the threshold was devised to prevent facilities from discharging residents prematurely. The threshold was developed based on an analysis of the amount of care required by participants in the state's Community Options (Medicaid Waiver) program and the Community Integration Program and reflects a higher level of care than the average community client.

The hours of service include staff time attributable to providing or arranging supportive, personal and nursing services including nursing assessment, documentation and consultation, and standby assistance. Services that are not included are meals, laundry, social and recreational activities.

Tenants have the right to contract for or arrange for additional services outside the service agreement.

Financing

The bill limits state reimbursement to 85% of the average statewide Medicaid nursing home rate excluding room and board. The statewide average rate for services in 1993-l 994 was $1215 to $1308. Rates would be established each year by July 1 st. The Department of Health and Social Services would be responsible for developing the rates which have to be approved by the Department of Administration. State

officials are planning to develop a tiered rate structure that reflects varying service needs. Facilities would be reimbursed as waiver slots are available.

Medications

Facilities can offer medication administration and medication management (storage, preparation or organization or reminder system, assessment of effectiveness of medications, monitoring of side effects, negative reactions and drug interaction and delegation and supervision of administration).

Staffing

Service staff are required to have training or experience in the physical, functional and psychological aspects of aging, the purpose and philosophy of assisted living, and the assigned duties and responsibilities.

WYOMING

Category Assisted living **Model** institutional

General approach

In 1992, the Director of the Department of Health formed a task force to determine how board and care homes can be established as low cost options in the continuum of care for the elderly. The task force reviewed who qualifies, current and future needs, existing and potential resources and cost reimbursement options. The task force included state agencies including the housing agency, ombudsman, consumer advocacy (AARP), home health agencies, not-for-profit nursing homes, board and care homes, and domiciliary care homes. The group's report was issued in October, 1992. In 1993, the legislature passed a definition of assisted living that allowed limited nursing care to be provided. Regulations were effective in October 1994 that re-name and modify the board and care licensure category. Board and care facilities can also be licensed as an assisted living facility in order to provide limited skilled nursing services and medication administration.

Definition

The statute defines assisted living as "a dwelling operated by any person, firm or corporation engaged in providing limited nursing care, personal care and boarding home care, but not habilitative care, for persons not related to the owner of the facility." Boarding home care means "a dwelling or rooming house operated by any person, firm or corporation engaged in the business of operating a home for the purpose of letting rooms for rent and providing meals and personal daily living care, but not habilitative or nursing care, or personal not related to the owner."

Unit requirements

A maximum of two people may share a bedroom. Bedrooms include toilets and sinks. One tub and shower room is required for every ten residents.

Tenant policy

The regulations now allow residents who need limited nursing to be served. Previously, residents needing skilled nursing had to transfer to a nursing facility. However, residents who wander or need wound care, stage II skin care, are incontinent or need total assistance with bathing and dressing, continuous assistance with transfer and mobility may not be served.

Services

The facility must describe the services provided and the charges for services. Facilities must provide meals, housekeeping, personal and other laundry services, assistance with transportation, assistance obtaining medical, dental and optometric care and social services, partial assistance with personal care, limited assistance with dressing, minor non-sterile dressing changes, stage I skin care, infrequent assistance with mobility, cuing for ADLs with visually impaired residents and intermittently confused and/or agitated residents requiring occasional reminders to time, place and person, care for residents who care for their own catheter/ostomy without assistance, care for residents who are incontinent but care for themselves, RN assessments and medication review, and 24 hour supervision.

Services that may not be provided in assisted living include continuous assistance with transfer and mobility, care for residents who cannot feed themselves independently, total assistance with bathing or dressing, provision of catheter or ostomy care, care of residents who are on continuous oxygen if monitoring is required, residents whose medical condition requires more than 7 days bedrest, residents who wander, need stage II skin care and beyond, wound care and incontinence care.

Financing

The task force report recommended that the Wyoming Department of Commerce be authorized to make loans to finance the development, remodeling and construction of board and care and/or assisted living facilities in underserved communities. No subsidies are available for low income residents.

Medications

The regulations allow assistance with self-administration which includes but is not limited to reminders, removing from containers, assistance with removing caps, and observing the resident take the medication.